

# Oceania Care Company Limited - Otumarama Home & Hospital

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Current Status: 19 February 2014

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

## General overview

This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standards and the District Health Board contract. The facility is operated by Oceania Care Company Limited.

Otumarama home and hospital provides care for up to 51 residents for rest home, hospital, and residential disabilities (physical and intellectual). On the days of this unannounced surveillance audit there were 40 residents residing at the facility.

One area identified requiring improvement at the last certification audit around care plan documentation is fully attained.

There are areas identified at this surveillance audit that require improvement around hot water temperatures, activities care plan evaluations, consent for residents' using restraint and documentation of restraint risks.

## Audit Summary as at 19 February 2014

Standards have been assessed and summarised below:

### Key

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

	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
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### Consumer Rights as at 19 February 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 19 February 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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### Continuum of Service Delivery as at 19 February 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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### Safe and Appropriate Environment as at 19 February 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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### Restraint Minimisation and Safe Practice as at 19 February 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk.
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### Infection Prevention and Control as at 19 February 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## Audit Report

<b>Legal entity name:</b>	Oceania Care Company Limited
<b>Certificate name:</b>	Oceania Care Company Limited - Otumarama Home & Hospital
<b>Designated Auditing Agency:</b>	Health Audit (NZ) Limited
<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Otumarama Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Intellectual; Residential disability services - Physical
<b>Dates of audit:</b>	<b>Start date:</b> 19 February 2014 <b>End date:</b> 20 February 2014
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	40

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	4
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	12	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2.5

## Sample Totals

Total audit hours on site	24	Total audit hours off site	10.5	Total audit hours	34.5
Number of residents interviewed	6	Number of staff interviewed	8	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	12	Total number of staff (headcount)	43	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	5			Number of GPs interviewed	1

## Declaration

I, XXXXX, Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Health Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Monday, 3 March 2014

## Executive Summary of Audit

### General Overview

This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standards and the District Health Board contract.

The facility is operated by Oceania Care Company Limited.

Otumarama home and hospital provides care for up to 51 residents for rest home, hospital, residential disabilities (physical and intellectual) and chronic conditions contracts.

On the days of this unannounced surveillance audit there were 40 residents residing at the facility. The 40 residents included 16 rest home and ten hospital residents. Seven residents were under the residential disabilities contract, of which four residents were rest home level care and three residents at hospital level care. Seven residents were under the chronic conditions contract of which five residents were rest home level care and two residents were at hospital level care.

One area identified requiring improvement at the last certification audit around care plan documentation is fully attained.

There are areas identified at this surveillance audit that require improvement around hot water temperatures, activities care plan evaluations, consent for residents' using restraint and documentation of restraint risks.

### Outcome 1.1: Consumer Rights

An open disclosure policy is documented and implemented. Interpreter services are available, if required. The complaints process is made known to residents and families on admission and displayed in the facility. Staff, residents and family interviewed demonstrate an understanding of the complaints process. A complaints register is maintained and up to date.

### Outcome 1.2: Organisational Management

Oceania Care Company, the governing body has established systems in place which define the scope, direction and goals of the organisation and the facility, and the monitoring and reporting processes against these systems. Quality improvement data is reported on to the governing body via the intranet monthly. Monitoring and communication of quality improvement data occurs via the management, registered nurses, quality improvement and staff meetings. Internal audits are conducted and where corrective actions are required this is documented, implemented and there is evidence of completion.

Otumarama home and hospital is managed by a business and care manager, a registered nurse with aged care experience, who is supported by a clinical leader, a registered nurse and a clinical and quality manager from Oceania.

The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is evidence in the residents' files reviewed of adverse event reporting and this is also reported monthly to Oceania. Residents files reviewed also provide

evidence of communication with families following adverse events or change in resident's condition.

The human resource management system provides for the implementation of processes both at the start of employment and on an ongoing basis in relation to education and training. There are regular in-service education and training opportunities provided for staff. A sampling of staff records evidences human resource processes are followed.

There is a documented rationale for determining staff levels and staff skill mixes. There is a registered nurse on duty 24 hours a day with on-call support from the business and care manager and the clinical leader.

### **Outcome 1.3: Continuum of Service Delivery**

Residents receive services from suitably qualified and experienced staff. Health care services are provided within the timeframes that safely meet the needs of residents.

Residents receive adequate and appropriate services meeting their assessed needs.

Activities are appropriate to the needs of the different resident groups reflecting needs. The activities coordinator prepares monthly activity programmes for the different areas of service with specific needs of the residents under 65 taken into consideration. There is a requirement for improvement relating to evidence that the activity plans are reviewed in a timely manner.

The previous area for improvement relating to the long term care plan not reflecting changes in a resident's condition and short term care plans not being recorded is fully implemented.

The medicines management system guides safe and appropriate prescribing, dispensing, administration of medicines, review, storage, disposal and medicines reconciliation in line with legislation, protocols and guidelines.

Service providers responsible for medicines management are competent. Annual medicines management training occurs. The residents who self-administer medicines have three monthly competencies reviews, are monitored daily by the RN's, and have safe storage for keeping the medicines. Medicines charts are legible with the general practitioner signing entries and discontinued medicines. Allergies are identified and the medicines records reflect the allergy status of residents. The dangerous drugs are double locked and the controlled drug register entries are in line with legislation. Medicines fridge temperatures are maintained and recorded.

Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guideline. Menus are reviewed annually. The cook receives a duplicate of the dietary plan for new residents in order to ensure dietary needs of the residents are implemented. Food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.

### **Outcome 1.4: Safe and Appropriate Environment**

There is current building warrant of fitness.

Documented systems are in place for essential, emergency and security services. Staff interviews and review of staff files provide evidence of current education and training in relevant areas. There is an area requiring improvement around hot water temperatures to be within recommended range.

## Outcome 2: Restraint Minimisation and Safe Practice

Restraints and enablers are assessed and residents have restraint and enablers included in their care plans. Staff members monitor restraints. Three of the reviewed residents who use restraint or enablers do not have restraint consents signed and two do not have any restraint risks identified.

## Outcome 3: Infection Prevention and Control

There are infection control policies and procedures to guide staff in all areas of infection control practice. Staff interviews confirm staff are familiar with infection control measures at the facility.

Surveillance for infections is carried out at the facility and results of surveillance are evaluated and reported on monthly to the Oceania head office via intranet.

The infection control committee and infection control coordinator are responsible for surveillance. Surveillance is appropriate to the size and complexity of the organisation. Surveillance is recorded and reported to management. Recommendations relating to achieving infection reduction and prevention outcomes are acted upon. Surveillance results are communicated to staff at quality improvement and staff meetings.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	2	1	0	0
Criteria	0	37	0	2	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	61

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	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,	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and the setting of the service.				
HDS(C)S.2008	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.	PA Low	Two out of five resident activity plans are not reviewed in a timely manner.	Provide evidence the activity plans are reviewed in a timely manner.	90
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	Hot water temperatures are monitored at monthly intervals, however is not delivered in line with the recommended temperature range.	Provide evidence the hot water temperatures are delivered in line with the recommended temperature range.	30
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Moderate			
HDS(RMSP)S.2008	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	PA Moderate	Three of the four residents do not have restraint consents signed and two do not have any risks identified.	Provide evidence restraint consents are signed and restraint risks are identified for residents.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		safety.				

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are policies and procedures in place to support the open disclosure practice in the facility. Staff education on open disclosure was last provided in October 2013. Incident forms and residents progress notes evidence family are informed of adverse events or when resident's condition alters.

Residents and family interviewed confirm that staff communicate well with them.

The business and care manager advises there are no residents requiring interpreter services at time of audit.

ARC requirement met.

### Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>The complaints policy and procedures are congruent with Right 10 of the Code of Rights. There is a complaints register which is current and monitored by the business and care manager. Complaints registers for 2013 and 2014 and annual complaints analysis for 2013 were reviewed.</p> <p>Complaints procedure audit was last conducted in January 2014 with corrective action required, this is documented and implemented. Staff education on complaints processes was last conducted in March 2013 and staff interviews confirm they are aware of the complaints process.</p> <p>The complaints process documentation is included in the facility welcome and information pack and located at entrance to the facility. Family and residents interviewed are aware of the complaints processes.</p> <p>The business and care manager states there has not been any complaints since the last certification audit, referred to the Health and Disability Commission, police, coroner, accident corporation or Ministry of Health. ARC requirements are met.</p>

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

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

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

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

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

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

**Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

### Evidence:

Oceania Care Company Limited has systems in place which record the scope, direction and goals of the organisation and the facility. Monthly reports to the governing body are provided by the business and care manager via the Oceania intranet and include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators, sighted. Oceania values, mission statement and philosophy are displayed at entrance to the facility.

Otumarama business plan was sighted (dated February 2013) and the business and care manager states is due for review this month. The monthly business status reports were sighted and these reports are provided to the Oceania executive team and the board and link to the facility's business plan.

The business and care manager is a registered nurse with current practicing certificate and has been in this position for nearly three years and is supported in their role by a clinical leader and Oceania quality and clinical manager. The business and care manager has completed the National Diploma in Business. All staff requiring practising certificates have current practising certificates.

Otumarama home and hospital has contracts with Nelson Marlborough District Health Board (DHB) for aged related residential care for hospital services (medical and geriatric) and rest home services; aged related residential respite care; residential disability services (intellectual and physical) and chronic health conditions. ARC requirements met.

## Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

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

**Attainment and Risk:** FA

### Evidence:

### Finding:

### Corrective Action:

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

### Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

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

### Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are quality and risk management systems in place including a clinical risk management plan and quality improvement policy, sighted. There is evidence the quality improvement data is collected, collated, evaluated, and analysed to identify trends and if corrective actions are required this is developed and implemented.</p> <p>An internal audit schedule and completed audits for 2013 and 2014 were reviewed. Quality and risk management data and quality improvement data is reported at the facility's meetings. Meeting minutes reviewed evidence this. Quality improvement and staff meeting are held monthly and there is evidence of quality activities discussed. Monthly report of the facility clinical indicators is attached to the minutes of meetings. Registered nurses meetings are conducted monthly. Sighted resident meeting minutes for June, August, September and November 2013.</p> <p>Policies and procedures reflect current accepted good practice and reference legislative requirements. Staff interviews (three health care assistants, two registered nurses) confirm staff are informed of new / updated policies and staff signing sheet demonstrate staff have read and understand the new/ reviewed policies. Document control policy and procedure for new or reviewed documents is recorded and implemented.</p> <p>Health and safety manual documents health and safety management systems including health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements emergency plan. Hazard registers were sighted. Minutes of health and safety meetings were sighted (February 2014) and evidence discussion and reporting on accident/ incidents; hazards; staff wellness programme, health and safety objectives and maintenance. Oceania holds Workplace Safety Management Practices at tertiary level for ACC workplace safety and this expires on 31st March 2015 ARC requirements are met.</p>

**Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

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

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

**Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

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

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

**Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

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

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

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

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

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

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

### Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

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

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

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

### Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is an adverse event reporting system in place. All accident/incidents are recorded and reported on the Oceania intranet as part of the monthly clinical indicators that record incidents relating to absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse. Communication with families following adverse events, or any change in resident's condition is evidenced in the residents' files reviewed. Staff education in adverse reporting was last conducted in October 2013 and staff interviews confirm awareness of the adverse event process.</p> <p>Staff are made aware of their essential notification responsibilities through their job descriptions, Oceania policies and procedures and professional codes of conduct.</p> <p>Accident /incident audit was last conducted in September 2013 with 100% compliance.</p>

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are policies and procedures in relation to human resource management. A competency register and staff education records are maintained, sighted. Staff education plan and attendance records were sighted for 2013 and 2014.

Annual practising certificates are current for all staff who require them to practice.

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff interviews confirm orientation / induction is provided for new staff.

Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals. Five of five staff files evidence human resources systems are adhered to.

ARC requirements are met.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are documented staffing rationale policies for determining staffing levels and skill mixes.          Staff interviews confirm staff are able to get through their work.          Residents interviewed state the care they receive is appropriate to their needs.</p>

Rosters evidence business and care manager and the clinical leader work Monday to Friday and on call after hours. There is a registered nurse cover 24/7  
ARC requirements are met.

**Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

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

**Outcome 1.3: Continuum of Service Delivery**

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

**Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)**

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  The residents receive services from staff that are suitably qualified and experienced and competent to perform their roles, sighted competencies and training for staff. Health care services are provided within the timeframes that safely meet the needs of the residents.  T1. Tracer methodology XXXXXX <i>This information has been deleted as it is specific to the health care of a resident.</i>  T2. Tracer methodology on a resident under 65 XXXXXX <i>This information has been deleted as it is specific to the health care of a resident.</i>

T3. Tracer methodology on a physically disabled resident

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

T4. Tracer methodology on a resident over 65 in the hospital:

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

T5. Tracer methodology on a resident over 65 in the rest home:

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

ARC requirements are met.

**Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

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

**Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

**Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

**Attainment and Risk:** FA

**Evidence:**

Residents receive adequate and appropriate services meeting their assessed needs, however service delivery relating to activities (refer to criterion 1.3.7.1) and service delivery relating to restraint (refer to criterion 2.1.1.1) do not consistently meet the needs of the residents. Five of the five reviewed resident files confirm that services are provided, consistent with, and contribute to meeting their assessed needs.  
ARC requirements are met.

**Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Activities are appropriate to the needs of the different resident groups reflecting the needs that are congruent to their age, culture and their abilities. the activities coordinator (AC) prepares monthly activity programmes with specific activities for rest home and hospital residents over 65, residents under 65 in the rest home and the hospital, specific activities for young people with intellectual disabilities, activities for young people with physical disabilities and activities that are specifically for younger residents regardless of their physical or intellectual abilities, sighted the activities programmes for November, December 2013 and February 2014. Activities are planned and provided to maintain strengths and skills and resident interviews confirm activities are meaningful and enjoyable to residents. The activities coordinator attends bi-monthly training days lead by a diversional therapist (DT) with other facilities, and the alternate months provide meeting opportunities for discussion and idea sharing, confirmed during the interview with the activities coordinator. There is a requirement for improvement relating to the activity plans to be reviewed in a timely manner.  
ARC requirements are not fully met.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Activities are appropriate to the needs of the different resident groups. Sighted the activities programmes for November, December 2013 and February 2014. Activities are planned and provided to maintain strengths and skills. Resident interviews confirm activities are meaningful and enjoyable.

**Finding:**

Two out of five resident activity plans are not reviewed in a timely manner.

**Corrective Action:**

Provide evidence the activity plans are reviewed in a timely manner.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The previous area for improvement where a) one out of 13 residents care plans was not amended when the resident's condition altered and b) short term problems were not recorded on short term care plans, is fully implemented. Evaluations are documented and care plans reflect the degree of achievement and response to the interventions as well as the progress of residents towards meeting desired outcomes.

Where the progress of a resident is not as expected the care plan is revised according to the current status of the resident, five resident files were reviewed. ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)**

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

**Attainment and Risk:** FA

**Evidence:**

The medicines management system guides safe and appropriate prescribing, dispensing, administration of medicines, review, storage, disposal and medicines reconciliation in line with legislation, protocols and guidelines.

Service providers responsible for medicines management are competent to perform the function. Annual medicines management competencies are completed by all staff members who administer medicines, sighted competencies.

Medicines management training last occurred in August 2013.

The service currently has two residents who self-administer medicines. The two residents who self-administer medicines have three monthly competencies reviews performed by their general practitioners (GP's) and the registered nurse (RN), are monitored daily by the RN's, and have safe storage ( a locked drawer) for keeping the medicines.

Twelve out of 12 medicines charts are legible with the general practitioner (GP) signing all new entries and discontinued medicines. Allergies are identified and the medicines charts state where the resident has no known allergies. Each medicines chart had photo identification and there is evidence of medicines reconciliation taking place on admission and where residents return from other health services.

The dangerous drugs are locked in a safe within a locked cupboard. The controlled drug register entries are in line with legislation and checked weekly, sighted.

Medicines fridge temperatures are maintained and recorded. Random checks on medicines for expiry dates confirm medicines being within it use timeframes.

ARC requirements are met.

### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

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

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

**Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)**

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and are appropriate to the resident groups. The menu was last reviewed by the dietitian during January 2014.</p> <p>The person who is currently standing in for the regular cook has experience in cooking for large numbers of people and feedback from residents is positive.</p> <p>The cook receives a duplicate of the dietary plan for new residents in order to ensure up to date information relating to the specific dietary needs of the residents.</p> <p>The kitchen is clean and tidy and the food is labelled and dated. Fridge / freezer temperatures are monitored daily and food temperatures are taken at every meals, sighted the records for January and February 2014.</p> <p>The person standing in for the cook completed infection control prevention training and completed food safety training.</p> <p>Food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.</p> <p>ARC requirements are met.</p>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

### Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The building has a current Building Warrant of Fitness that expires on 11 April 2014. There is a planned and reactive maintenance programme in place, medical equipment is safely stored and has been calibrated and electrical equipment has been checked. Interview with the maintenance person confirms the planned maintenance programme is followed.

Corridors are clutter free and wide enough to allow residents to pass each other safely. Floor surfaces are maintained in good order without abrupt change in gradient. Residents interviewed confirm they are able to move freely around the facility and external areas and that the accommodation meets their needs.

The external areas are safe and accessible and are appropriate to the resident group and setting. Shading and seating in external areas is provided and used by residents on audit days.

Hot water temperatures are monitored and recorded monthly, however hot water temperatures readings evidence the hot water is above the recommended temperature range and this requires an improvement.  
ARC requirements are met.

#### Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** PA Low

**Evidence:**

The hot water temperatures records were sighted and evidence the hot water monitoring is conducted monthly. The hot water temperatures records evidence the temperatures are above the recommended range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions). Discussions held with the business and care manager and the maintenance person were conducted and corrective action was put in place. The plumber was on site on the second day of audit.

**Finding:**

Hot water temperatures are monitored at monthly intervals, however is not delivered in line with the recommended temperature range.

**Corrective Action:**

Provide evidence the hot water temperatures are delivered in line with the recommended temperature range.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** PA Moderate

**Evidence:**

Restraints and enablers are included in resident care plans. Staff members monitor restraints according to the timeframes identified during the restraint assessment and restraint reviews are conducted at each resident review. Three of the residents who use restraint or enablers do not have restraint consents signed and two do not have any restraint risks identified.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The use of enablers is voluntary and the service follows the least restrictive option in order to meet the resident's needs. Four resident files were reviewed regarding restraint and enabler use.

**Finding:**

Three of the four residents do not have restraint consents signed and two do not have any risks identified.

**Corrective Action:**

Provide evidence restraint consents are signed and restraint risks are identified for residents.

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

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

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## **Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)**

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

**Attainment and Risk:** FA

**Evidence:**

The infection control policies and procedures manual details surveillance processes. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection control nurse is the clinical leader, position description sighted in the clinical leader's file reviewed.

Infection logs are maintained and numbers of infections are collated at the end of each month and reported as a clinical indicator to management, staff at meetings and to Oceania. Clinical staff interviewed report they are made aware of any infections of individual residents by way of feedback from registered nurses and handovers.

Norovirus outbreak occurred in April 2013 and documentation evidences notification of the outbreak to the Public Health Service. Summary of the outbreak data was sighted.

The infection control committee and infection control coordinator (ICC) are responsible for surveillance within the service.

Results and conclusions of surveillance are recorded and reported to management. Recommendations relating to achieving infection reduction and prevention outcomes are acted upon and evaluated. Infection control results are communicated to relevant personnel and management in a timely manner, sighted monthly infection control and prevention surveillance reports for October, November, December 2013 and January 2014.

Surveillance results are communicated to staff at quality improvement and staff meetings.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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