

Oceania Care Company Limited - West Harbour Lodge

Current Status: 10 March 2014

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 and NZS8134.3:2008) on the audit date(s) specified.

General overview

West Harbour Lodge can provide care for up to 68 residents (20 rest home specific beds, 44 hospital beds with five beds that can be used for either rest home or hospital level care). During the audit there were 64 residents living at the facility including 23 residents at the rest home level of care and 41 residents at hospital level of care. The business and care manager is responsible for the overall management of the facility and has been in the role for three weeks. The business and care manager is a registered nurse, has a diploma in facility management and over 20 years' experience in aged care including previous management role at another Oceania facility. The clinical manager provides clinical oversight and both are supported by the clinical and quality manager who is also a registered nurse. Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys.

The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads and acuity with rosters indicating that staffing reflects resident acuity and bed occupancy. There is one registered nurse on in the hospital area at all times with a second registered nurse on in the morning shift in the rest home. Residents are supported by health care assistants with residents and family stating that they receive a high standard of support.

Improvements are required to corrective action planning, short term care planning, activity planning and documentation around crushed medication.

Audit Summary as at 10 March 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

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

Consumer Rights as at 10 March 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 10 March 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.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 10 March 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 10 March 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.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 10 March 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 10 March 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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Audit Results as at 10 March 2014

Consumer Rights

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers' rights, access to advocacy services and how to lodge a complaint is available to residents and their family. The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent policy and processes are implemented by the service, meeting contractual requirements. Staffs ensure residents are informed and have choices related to the care they receive. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

Organisational Management

Oceania has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. Quality and risk performance is reported across the facility meetings and monitored by the organisation's management team through the business status reports. Benchmarking reports are produced that include incidents/accidents, infections and complaints. These are used to provide comparisons with other facilities.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation/induction programme that provides new staff with relevant information for safe work practice and an ongoing training programme. There is a policy for determining staffing and skill mix for safe service delivery. Staff identify that staffing levels are adequate and interviews with residents and relatives demonstrated that they have adequate access to staff to support residents when needed.

There is a new business and care manager appointed who has been in the position for three weeks who has extensive experience in aged care and in facility management roles and is a registered nurse. The business and care manager is supported by a clinical manager who has a background in medical nursing and has been with the service for two and a half years and the clinical and quality manager who supports a number of sites.

An improvement is required to corrective action planning.

Continuum of Service Delivery

There are clearly documented processes for entry to the facility. Admissions are managed in a timely manner by competent staff. Adequate information about the facility is made available for the resident/families. Admission information includes eligibility of the resident to the level of care provided by the facility.

Care is provided by a range of health professionals including RNs, GP, diversional therapist, and physiotherapist and visiting allied health personnel. Residents/families are involved with goal setting and reviews. Resident's independence and choice are encouraged. Referrals and transfers are managed in a timely manner by competent staff.

Assessments are comprehensive and care plans are fully documented, interventions are consistent with good practice and desired outcomes are documented. Short term care plans for some acute conditions are not always in place. The activities programme is of a high standard and are relevant to the needs and previous interests, hobbies, culture and ability of the residents. An activity plan for each resident needs to be created by the diversional therapist.

West Harbour Lodge provides safe and appropriate medication management system in line with the legislation. Guidelines for crushing of medications must be in place for safe administration. A medication system is implemented. There are policies and procedures for medicine management. All medicines are prescribed by the GP using pharmacy generated medication charts, photos and allergies. Three monthly GP reviews are conducted. A pharmacy returns policy and procedure is implemented. Medications are administered by staff assessed as competent. There are seven residents who self-administer inhalers which are kept in a lockable cupboard.

Fluid and nutritional needs of the residents are assessed and the menus are reviewed by the dietician. Special dietary needs are catered for the residents. Food practices comply with current legislation and good practice.

Safe and Appropriate Environment

All building and plant comply to legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. There are adequate numbers of toilets and showers across the facility with access to a hand basin and paper towels. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Activities can occur in any of the lounges and furniture is arranged to ensure residents are able to move freely and safely. Laundry is outsourced and the managers and staff monitor cleaning to ensure that the facility is spotless.

Essential emergency and security systems are in place with regular fire drills completed. Emergencies, and first aid are included in the training programme. There is a civil defence kit for the whole facility. Call bells are evident across the facility in resident's rooms, lounge areas, and toilets/bathrooms and all are monitored to ensure that they are functioning at all times.

Restraint Minimisation and Safe Practice

West Harbour Lodge actively minimises the use of restraints. There are eight residents on restraint and there are adequate documented guidelines on the use of restraints and enablers. One resident who uses a bedrail as an enabler is voluntary and the least restrictive option. Restraint

minimisation policies and procedures are implemented in practice. There are no restraint-related injuries reported. Definitions are congruent with requirements of the HDSS standards. Restraint competencies are current and staffs receive adequate training. The restraint coordinator conducts restraint in-service trainings annually. The restraint register is current and updated by the restraint coordinator.

Restraint is incorporated in the care plan.

Infection Prevention and Control

West Harbour Lodge's infection control programme is clearly documented and is suitable for the facility as well as the level of care provided. There is a designated infection control leader with clearly defined responsibilities. The infection surveillance programme is appropriate for the size of the facility. Antibiotics are monitored monthly as well as the treatment outcomes. Preventative response or corrective action is recorded and implemented. Staff interviewed report that they are made aware of the infections through the monthly staff meetings and handovers. The infection control programme is reviewed annually to ensure that prevention and control processes are up to date.

HealthCERT Aged Residential Care Audit Report (version 4.0)

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

Legal entity name:	Oceania Care Company Limited		
Certificate name:	Oceania Care Company Limited - West Harbour Lodge		
Designated Auditing Agency:	Health Audit (NZ) Limited		
Types of audit:	Certification Audit		
Premises audited:	West Harbour Lodge		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
Dates of audit:	Start date: 10 March 2014	End date: 11 March 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			64

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	8
Other Auditors	XXXXX	Total hours on site	12	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	4

Sample Totals

Total audit hours on site	24	Total audit hours off site	16	Total audit hours	40
Number of residents interviewed	9	Number of staff interviewed	9	Number of managers interviewed	3
Number of residents' records reviewed	8	Number of staff records reviewed	9	Total number of managers (headcount)	3
Number of medication records reviewed	16	Total number of staff (headcount)	65	Number of relatives interviewed	8
Number of residents' records reviewed using tracer methodology	2			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	Not Applicable
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, 24 March 2014

Executive Summary of Audit

General Overview

West Harbour Lodge can provide care for up to 68 residents (20 rest home specific beds, 44 hospital beds with five beds that can be used for either rest home or hospital level care). During the audit there were 64 residents living at the facility including 23 residents at the rest home level of care and 41 residents at hospital level of care. The business and care manager is responsible for the overall management of the facility and has been in the role for three weeks. The business and care manager is a registered nurse, has a diploma in facility management and over 20 years' experience in aged care including previous management role at another Oceania facility. The clinical manager provides clinical oversight and both are supported by the clinical and quality manager who is also a registered nurse. Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys. The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads and acuity with rosters indicating that staffing reflects resident acuity and bed occupancy. There is one registered nurse on in the hospital area at all times with a second registered nurse on in the morning shift in the rest home. Residents are supported by health care assistants with residents and family stating that they receive a high standard of support. Improvements are required to corrective action planning, short term care planning, activity planning and documentation around crushed medication.

Outcome 1.1: Consumer Rights

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers' rights, access to advocacy services and how to lodge a complaint is available to residents and their family. The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent policy and processes are implemented by the service, meeting contractual requirements. Staffs ensure residents are informed and have choices related to the care they receive. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

Outcome 1.2: Organisational Management

Oceania has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. Quality and risk performance is reported across the facility meetings and monitored by the organisation's management team through the business status reports. Benchmarking reports are produced that include incidents/accidents, infections and complaints. These are used to provide comparisons with other facilities. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation/induction programme that provides new staff with relevant information for safe work practice and an ongoing training programme. There is a policy for determining staffing and skill mix for safe service delivery. Staff identify that staffing levels are adequate and interviews with residents and relatives demonstrated that they have adequate access to staff to support residents when needed. There is a new business and care manager appointed who has been in the position for three weeks who has extensive experience in aged care and in facility management roles and is a registered nurse. The business and care manager is supported by a clinical manager who has a background in medical nursing and has been with the service for two and a half years and the clinical and quality manager who supports a number of sites. An improvement is required to corrective action planning.

Outcome 1.3: Continuum of Service Delivery

There are clearly documented processes for entry to the facility. Admissions are managed in a timely manner by competent staff. Adequate information about the facility is

made available for the resident/families. Admission information includes eligibility of the resident to the level of care provided by the facility.

Care is provided by a range of health professionals including RNs, GP, diversional therapist, and physiotherapist and visiting allied health personnel. Residents/families are involved with goal setting and reviews. Resident's independence and choice are encouraged. Referrals and transfers are managed in a timely manner by competent staff.

Assessments are comprehensive and care plans are fully documented, interventions are consistent with good practice and desired outcomes are documented. Short term care plans for some acute conditions are not always in place. The activities programme is of a high standard and are relevant to the needs and previous interests, hobbies, culture and ability of the residents. An activity plan for each resident needs to be created by the diversional therapist.

West Harbour Lodge provides safe and appropriate medication management system in line with the legislation. Guidelines for crushing of medications must be in place for safe administration. A medication system is implemented. There are policies and procedures for medicine management. All medicines are prescribed by the GP using pharmacy generated medication charts, photos and allergies. Three monthly GP reviews are conducted. A pharmacy returns policy and procedure is implemented. Medications are administered by staff assessed as competent. There are seven residents who self-administer inhalers which are kept in a lockable cupboard.

Fluid and nutritional needs of the residents are assessed and the menus are reviewed by the dietician. Special dietary needs are catered for the residents. Food practices comply with current legislation and good practice.

Outcome 1.4: Safe and Appropriate Environment

All building and plant comply to legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. There are adequate numbers of toilets and showers across the facility with access to a hand basin and paper towels. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Activities can occur in any of the lounges and furniture is arranged to ensure residents are able to move freely and safely. Laundry is outsourced and the managers and staff monitor cleaning to ensure that the facility is spotless.

Essential emergency and security systems are in place with regular fire drills completed. Emergencies, and first aid are included in the training programme. There is a civil defence kit for the whole facility. Call bells are evident across the facility in resident's rooms, lounge areas, and toilets/bathrooms and all are monitored to ensure that they are functioning at all times.

Outcome 2: Restraint Minimisation and Safe Practice

West Harbour Lodge actively minimises the use of restraints. There are eight residents on restraint and there are adequate documented guidelines on the use of restraints and enablers. One resident who uses a bedrail as an enabler is voluntary and the least restrictive option. Restraint minimisation policies and procedures are implemented in practice. There are no restraint-related injuries reported. Definitions are congruent with requirements of the HDSS standards. Restraint competencies are current and staffs receive adequate training. The restraint coordinator conducts restraint in-service trainings annually. The restraint register is current and updated by the restraint coordinator. Restraint is incorporated in the care plan.

Outcome 3: Infection Prevention and Control

West Harbour Lodge's infection control programme is clearly documented and is suitable for the facility as well as the level of care provided. There is a designated infection control leader with clearly defined responsibilities. The infection surveillance programme is appropriate for the size of the facility. Antibiotics are monitored monthly as well as the treatment outcomes. Preventative response or corrective action is recorded and implemented. Staff interviewed report that they are made aware of the infections through the monthly staff meetings and handovers. The infection control programme is reviewed annually to ensure that prevention and control processes are up to date.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	46	0	4	0	0	0
Criteria	0	95	0	4	0	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	0
Criteria	0	0	0	0	0	0	0	2

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	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.	PA Low			
HDS(C)S.2008	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.	PA Low	Not all improvements identified as being required have a corrective action plan documented or evidence of resolution of issues.	Ensure that all improvements identified as being required have a corrective action plan documented or evidence of resolution of issues.	90
HDS(C)S.2008	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.	PA Low			
HDS(C)S.2008	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	PA Low	One resident in the hospital has recurrent urinary tract infections. There is no short term care plan developed for	Ensure that short term care plans are developed for all acute infections and evaluation must be conducted in a timely	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		needs of the consumer.		the resident and no evidence of evaluation is sighted in the documentation.	manner.	
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, and the setting of the service.	PA Low			
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	All eight out eight residents file sampled have no activity plan in place, although monthly reviews are sighted in the progress notes.	Ensure that all residents will have an individual activity plan in place.	60
HDS(C)S.2008	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.	PA Low			
HDS(C)S.2008	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.	PA Low	Five medicines are crushed without appropriate documentations or guidance from either the pharmacy or from the GP. The clinical and quality manager (CQM) communicated to the CM via a memo that all crushed medications must not be administered to residents unless approved by the pharmacy and GP. This memo was not implemented accordingly but the CM ensures that the RNs will only crush	Ensure that guidelines are obtained and systems are implemented regarding crushing of medications.	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>medication after receiving guidelines from the pharmacy and with the approval of the GP. During the day of the audit, the CM was able to obtain guidelines from the pharmacy. The GP also confirms documenting the crushed medications in the resident's files accordingly. RNs are also reminded during the afternoon handover that medications can only be crushed after having the guidelines from the pharmacy and documentation by the GP.</p>		

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 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. Interviews with the clinical manager, five of five caregivers and two registered nurses confirm their understanding of the Code. Examples are provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.

The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information.

Training around the code of rights and complaints was last provided in May 2013. The auditors noted respectful attitudes towards residents on the day of the audit.

ARC requirements are met.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

A registered nurse discusses the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code are also held at during the monthly residents' meetings (meeting minutes sighted). Residents and family interviews confirm their rights are being upheld by the service. Information regarding the Health and Disability Advocacy Service is clearly displayed in multiple locations throughout the facility and in a brochure that is held at reception.

Code of rights leaflets are available at the front entrance of the service.

Code of rights posters are on the walls in the service.

Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the entrance to the service. If necessary, staff will read and explain information to residents as stated by the caregivers and registered nurses interviewed.

Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.

Nine residents (eight rest home and one hospital) and eight family members (five hospital and three rest home) interviewed are able to describe their rights and advocacy services particularly in relation to the complaints process.

ARC requirements are met.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

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.

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 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

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

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

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

Attainment and Risk: FA
Evidence: <p>The service has a philosophy that promotes dignity and respect and quality of life.</p> <p>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 with the registered nurses and clinical manager interviewed stating that the care plans are completed with the resident and family member (confirmed by residents and family interviewed). Interventions to support these are identified and evaluated. Residents are addressed by their preferred name and this is documented in eight of eight files reviewed.</p> <p>A policy is available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality (sexuality and intimacy) in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour. Staff have received training around sexuality and intimacy last in March 2014.</p> <p>The service ensures that each resident has the right to privacy and dignity, which is recognised and respected. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room.</p> <p>Five caregivers interviewed report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirm the residents' privacy is respected.</p> <p>Caregivers interviewed report that they encourage the residents' independence by encouraging them to be as active as possible. A physiotherapist is available six hours a week to assess and review residents. Caregivers assist residents with their activity programmes.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. They are committed to provide guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the organisation's mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code. Staff receive mandatory education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation. Staff interviewed are aware of the signs of abuse and neglect.</p> <p>Resident files reviewed (eight of eight) identifies that cultural and /or spiritual values, individual preferences are identified and these are discussed as part of the monthly meetings as issues are identified as described by the clinical manager. There are weekly Catholic services, monthly Anglican services and a small prayer group that</p>

comes in monthly.

There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.

ARC requirements are met.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

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

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 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

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.

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 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

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

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

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

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

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

Attainment and Risk: FA
Evidence: The service implements the Maori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan. Links to local kaumatua Maori services are documented and include the Awataha Marae Incorporated Society, Te Puna Hauora o te Raki Pae Whenua, Lady Allum iwi.

The clinical manager has actively tried to engage a family member who is a kaumatua at Waitemata District Health Board to become engaged with the service and initial meetings have occurred.
 There are six Maori residents living at the facility during this certification audit. There is one staff member who identifies as Maori.
 Staff interviewed report specific cultural needs are identified in the residents' care plans. This was further evidenced in eight of eight resident files selected for review (five hospital and three rest home).
 Staff are aware of the importance of whanau in the delivery of care for their Maori residents.
 Maori events are linked to the activities programme with a 'kiwi/Maori' cultural day held in November 2013.
 ARC requirements are met.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with 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.)

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

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

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

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

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

Attainment and Risk: FA
Evidence: <p>The service identifies each resident's personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline. Residents and family are involved in the assessment and the care planning processes, confirmed in interviews with residents and families. Information gathered during assessment includes the resident's cultural values and beliefs. This information is used to develop a care plan and includes input from the resident and their family (confirmed by nine residents including eight rest home and one hospital and eight family members including five hospital and three rest home. One family member of a resident states that her relative is well supported and her specific cultural norms are followed. A resident interviewed with English as a second language states that she is very well supported and cultural needs are addressed. ARC requirements are met.</p>

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

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.

Attainment and Risk: FA
Evidence:

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

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

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

ARHSS D16.5e

Attainment and Risk: FA
Evidence: <p>The facility implements Oceania policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues with a job description sighted on nine of nine staff files reviewed. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff including the diversional therapist, five caregivers across hospital and rest home, two registered nurses and the clinical manager confirm their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. ARC requirements are met.</p>

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

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.

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

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

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

Attainment and Risk: FA

Evidence:

West Harbour Lodge implements Oceania policies to guide practice. These policies align with the health and disability services standards and are reviewed annually. There is a quality framework that supports an internal audit programme. Benchmarking occurs across all the Oceania facilities. There is a training programme and managers are encouraged to complete management training. There is a monthly regional management meeting. Specialised training and related competencies are in place for the registered nursing staff. Residents and families interviewed expressed a high level of satisfaction with the care delivered. The general practitioner reports a high standard of care is provided at the service and the registered nurses demonstrate good clinical assessment skills. Consultation is available through the organisation's management team that includes registered nurse, dietician etc. A physiotherapist is available for six hours a week. Key projects that are currently in progress include the following: i) reassessment programme that is reviewing levels of care provided to residents, ii) introduction of Inter RAI, a project around nutrition and hydration facilitated by the dietician looking at management of weight loss and gain in residents, iii) putting together of palliative care kits for family members to use with residents to feel/look good, iv) the 'homely hotel' project, v) the Connect model of care project that aims at linking 'our people and our communities to created partnerships that develop and deliver excellence of care', vi) the continuous quality improvement project looking at addressing any improvements required through certification and surveillance audits with a long term focus on achieving continuous improvement ratings. The business and care manager, clinical manager and the clinical and quality manager are committed to improving service delivery at West Harbour Lodge. ARC requirements are met.

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

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

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 1.1.9: 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:

Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced in 20 of 20 completed accident/incident forms. Family contact is recorded in residents' files – sighted in eight of eight files reviewed. Interviews with eight family members (five hospital and three rest home) confirm they are kept informed. Family also confirm that they are invited at least annually to the care planning meetings for their family member. Family interviewed confirm that they are invited to attend the monthly resident meetings. Interpreter services are available when required from the District Health Board. An interpreter has been used for one resident after an incident to ensure that a professional person interpreted the results and findings correctly. Staff also interpret on a day to day basis with staff identifying as having a range of ethnicities/language including Fijian, Indian, Samoan etc. The information pack is available in large print and advised that this can be read to residents. Staff have had training around communication in January 2013 and 2014. Staff have had training around open disclosure last in March 2014 and training around the complaints process in July 2013. ARC requirements are 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.

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

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

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

Attainment and Risk: FA
Evidence: <p>There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. The policy determines that staff ensure all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care. Residents are able to make their wishes, requirements and expectations known and to trust that these will be followed.</p> <p>All resident files identified that informed consent is collected.</p> <p>Interviews with caregivers identify their understanding of informed consent processes. They described how informed consents are sought in the delivery of personal cares including daily choices and communication and this is confirmed by residents who identify that they are able to make choices.</p> <p>The service information pack includes information regarding informed consent.</p> <p>The registered nurse (RN) or by the clinical manager (CM) discuss informed consent processes with residents and their families/whānau during the admission process.</p> <p>The advance directive and consent policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of eight of eight files note that all have appropriately signed advanced directives. All have been signed on the day of admission.</p> <p>Discussion with family identifies that the service actively involves them in decisions that affect their relatives lives.</p> <p>ARC requirements are met.</p>

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

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.

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

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

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

Attainment and Risk: FA
Evidence: <p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service.</p> <p>The diversional therapist responsible for facilitating the monthly residents' meetings, reports information is regularly provided to the residents regarding their right to access advocacy services through HDC. Staff training on the role of advocacy services is included in training on The Code of Health and Disability Consumers' Rights – last provided for staff in May 2013.</p> <p>Discussion with family and residents identifies that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.</p> <p>The resident file includes information on resident's family/whanau and chosen social networks.</p> <p>Staff including the five caregivers interviewed are aware of the right for advocacy and how to access and provide advocacy information to residents if needed. ARC requirements are met.</p>

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

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.

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

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

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

Attainment and Risk: FA
Evidence: <p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings (earlier in winter to coincide with dusk) but visitors can arrange to visit after doors are locked. Families interviewed confirm they can visit at any reasonable time and are always made to feel welcome. Family were seen coming and going freely on the days of the audit. Residents are encouraged to be involved in community activities and maintain family and friends networks. Links are also encouraged through church with some residents still engaged in community activities including attending their own church services and going to activities at the local Massey hall. Residents have performing groups who entertain residents. Residents are included in shopping visits and outings with families. ARC requirements are met.</p>

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

Attainment and Risk: FA
Evidence:

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

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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

Attainment and Risk: FA
Evidence: <p>The organisation’s complaints policy and procedures is in line with the Code and includes time-frames for responding to a complaint. Complaint’s forms are available at the entrance.</p> <p>A complaints register is place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint’s folder.</p> <p>Two complaints lodged in 2013 were selected for review. There is documented evidence of time-frames being met for responding to these complaints.</p> <p>Nine residents (eight rest home and one hospital) and eight family members (five hospital and three rest home) all state that they would feel comfortable complaining. One family member states that a complaint had been made and this has been addressed through the care plan review.</p> <p>The clinical and quality manager states that there have been no complaints with the Health and Disability Commission since the last audit or with other authorities.</p> <p>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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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:

West Harbour Lodge is part of the Oceania group with the executive management team including the CEO (chief executive officer), general manager, operations manager, regional operational managers and clinical and quality managers providing support to the service.

Communication between the service and managers takes place on a monthly basis.

Oceania has a clear mission, values and goals. The vision is to be the provider of choice for senior New Zealanders of care and lifestyle options in a way that meets and exceeds the expectations of our residents, staff and stakeholders. The mission is 'we provide excellent contemporary care that reflects our residents' individuality and their right to choice, respect and dignity. We provide a positive and welcoming environment in which our residents are encouraged and supported to improve their quality of life'.

The facility can provide care for up to 68 residents (20 rest home specific beds, 44 hospital beds and there are five beds that can swing to either rest home or hospital-level care). During the audit there are 64 residents living at the facility including 23 residents at the rest home level of care and 41 residents at hospital level of care.

The business and care manager is responsible for the overall management of the facility. She has been in the role for three weeks following the resignation in January of the previous manager. The business and care manager is a registered nurse (registered nurse with current annual practicing certificate), has a diploma in facility management, over 20 years' experience in aged care including hospital/dementia/rest home level of care with 10 years' experience in management. The previous role was as business and care manager at another Oceania facility. Professional development relating to the management of an aged care facility exceeds eight hours over the three-month period of time that the business and care manager has been in the acting role.

ARC requirements are 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.

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

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

Attainment and Risk: FA
Evidence: <p>In the absence of the business and care manager, a clinical manager is in charge with support from the clinical and quality manager. The current clinical manager has been employed at the service for the past two and a half years, has a diploma in facility management and three and a half years' experience in aged care services. The clinical manager also has extensive experience in nursing in the District Health Board in medical wards.</p> <p>The clinical and quality manager provides support to a number of Oceania facilities. The clinical and quality manager is a registered nurse, has a certificate in business management, diploma in management and 13 years' experience in aged care including home care and hospital/rest home/dementia facilities. The clinical and quality manager has been in management roles for eight years and with Oceania for three years.</p> <p>ARC requirements are met.</p>

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

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

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <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

Attainment and Risk: PA Low
<p>Evidence:</p> <p>West Harbour Lodge uses the Oceania quality and risk management framework that is documented to guide practice. The business plan is documented and reported on through the business status reports.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy at the nurses stations and in the business and care managers office. New and revised policies are presented to staff to read and staff sign to stay that they have read and understood – sighted and confirmed by the five caregivers interviewed.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme (noting that not all improvements identified as being required have a corrective action plan documented or evidence of resolution of issues). An improvement is required to documentation of corrective action plans with evidence that issues are addressed. Where corrective actions are put into place (all completed until September 2013 and since the new business and care manager has been on site), there is documented evidence of communication with staff in the health and safety, infection control, quality and staff meetings as well as in the registered nurse and restraint meetings. All staff interviewed (five caregivers, two registered nurses, the clinical manager, the diversional therapist, one cook) report they are kept informed of quality improvements and corrective action plans. Results are benchmarked across all Oceania aged care facilities with a business status report completed by the business and care manager monthly (sighted). This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products.</p> <p>There is an annual family and resident satisfaction survey which took place in November 2013. The overall level of satisfaction rate of residents and families is satisfactory to very satisfactory.</p> <p>The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures, and a health and safety plan are in place for the service. There is a hazard management programme documented 2013-14 with a hazard register for each part of the service e.g. kitchen, office, care provision room. There is evidence of hazards identification forms completed when a hazard is identified and the hazard form updated. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.</p> <p>The organisation holds a current ACC Work Safety and Management Practice tertiary level accreditation.</p> <p>Health and safety is audited monthly.</p> <p>ARC requirements are met apart from the opportunity for improvement identified.</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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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.

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 1.2.3.8 (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.

Attainment and Risk: PA Low
<p>Evidence:</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme.</p> <p>There is a process for documentation of corrective action plans.</p> <p>The hazard register shows that all hazards identified are signed off with evidence of resolution of the issue in a timely manner.</p> <p>Corrective action plans were used with evidence of resolution of issues by the previous business and care manager until September 2013 and after that they are spasmodically documented as part of the internal audit process. They are now in place and used by the new business and care manager who is also in the process of going back to address the issues raised between September 2013 and January 2014 where there are gaps in documentation.</p>
<p>Finding:</p> <p>Not all improvements identified as being required have a corrective action plan documented or evidence of resolution of issues.</p>
<p>Corrective Action:</p> <p>Ensure that all improvements identified as being required have a corrective action plan documented or evidence of resolution of issues.</p>
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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.

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 1.2.4: 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

Attainment and Risk: FA
Evidence: <p>The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are no times since the last audit when authorities have had to be notified. There have been no outbreaks since the last audit.</p> <p>The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the clinical manager, business and care manager and clinical and quality manager.</p> <p>Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Twenty incident reports were selected for review. Each incident report had a corresponding note in the progress notes to inform staff of the incident. There was evidence of open disclosure for each recorded event.</p> <p>Information gathered is regularly shared at the monthly executive management and regional meetings with the business and care manager documenting incidents which are then graphed, trends analysed and benchmarking of data occurring.</p> <p>ARC requirements are met.</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.

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 1.2.4.3 (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.

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 1.2.7: 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

Attainment and Risk: FA
Evidence: All seven registered nurses, the clinical manager and the business and care manager hold current annual practising certificates. Visiting practitioner's practising certificates include the general practitioner, podiatrist, pharmacists and physiotherapist.

Nine staff files were randomly selected for audit (business and care manager, clinical manager, four health care assistants, one diversional therapist, one cook and one registered nurse). Appointment documentation is on file including signed contracts, job descriptions, reference checks and interviews. There is an annual appraisal process in place with all staff having a current performance appraisal. First aid and CPR certificates are held in the registered nurses staff files.

Police checks are completed at the head office.

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract.

Health care assistants are paired with a senior caregiver for shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and senior caregivers who administer medicines to residents. Other competencies are completed including hoist, oxygen use, hand washing, wound management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower.

The organisation has a mandatory education and training programme with sessions held monthly. Staff attendances are documented and there is evidence of good staff attendance. The five health care assistants state that they value the training. Education and training hours exceed eight hours a year.

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.

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

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.

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 1.2.7.4 (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.

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 1.2.7.5 (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.

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 1.2.8: 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

Attainment and Risk: FA

Evidence:

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.

The rosters for an occupancy of 41 hospital level residents and 23 rest home residents is as follows:

There is one registered nurse on in the hospital area at all times with a second registered nurse on in the morning shift in the rest home. There is always a senior/duty healthcare assistant on in the morning and afternoon shifts. There are six health care assistants in the hospital in the morning (three on a long shift and three short shift) and three in the rest home (two full and one short shift). There are five healthcare assistants in the hospital in the afternoon (two long and three short shifts) and two including the duty healthcare assistants in the afternoon in the rest home. There are three healthcare assistants on the night shift.

The business and care manager (RN) works full-time Monday – Friday and the clinical manager works full-time.

The new business and care manager confirms that there is to be an increase in staffing in the hospital by two healthcare assistants in the morning with the activities staff spread across seven days.

Residents and families interviewed confirm staffing is adequate to meet the residents' needs.

There are currently 65 staff including the business and care manager, clinical manager, seven registered nurses, a diversional therapist and two activities staff, maintenance, two cleaners a day for seven days a week, cooks seven days a week with kitchen assistants for support, an administrator and 47 healthcare assistants. 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.

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 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

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

Attainment and Risk: FA

Evidence:

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

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

Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member including designation.

Resident files are protected from unauthorised access by being locked away in an office. Informed consent is obtained from residents/family/whanau on admission to display photographs. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

Individual resident files demonstrate service integration. This includes medical care interventions. Medication charts are in a separate folder with medication and this is appropriate to the service.

ARC requirements are met.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

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 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

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

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

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

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

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

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.)

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 (HDS(C)S.2008:1.3.1)

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

Attainment and Risk: FA

Evidence:

Resident's entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. Admission agreements are in place for all residents and sighted which are kept in the office. On admission, the resident is orientated to the facility and is provided with a family information pack. The facility requires all residents to have NASC assessments to ensure that the facility is capable to meet the resident's needs. The registered nurses (RNs) and/or clinical manager (CM) admit new residents in the facility. Senior health care assistants obtain the resident's vital signs and weights. The RNs receive hand overs from the DHB hospital the day the resident is discharged to the facility.

The relevant ARC requirements are met.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

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.

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 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

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

Attainment and Risk: FA

Evidence:

There is an adequately documented process for the management of any declines to entry in the facility. Records of enquiries are maintained and, in the event of decline, information is given regarding alternative services and the reason/s for declining to services are clearly stated. Management assesses the suitability of the resident through an enquiry form which is kept in "The Way Forward" book. When not suitable, the family and/or resident is referred to other facilities. The CM reported that when social workers or NASC contact the facility for vacancy, a telephone information gathering process is obtained to ensure the eligibility of the resident to the facility.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

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.

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 1.3.3: 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

Attainment and Risk: PA Low

Evidence:

Resident's files sampled confirm that each stage of service provision is completed by a suitably qualified person. All assessments and care plans are developed and

reviewed by a registered nurse (RN) or by the clinical manager (CM). Daily interventions and support with activities of daily living are implemented with the help of trained healthcare assistants (HCAs) and qualified diversional therapist (DT) with two part-time activities assistants.

Timeframes for service delivery are defined and met as evident in eight out of eight resident's files sampled. An initial assessment is conducted on admission by either the RNs or by the CM using various risk assessment tools. A medical assessment is performed by the GP within 24-48 hours. An initial care plan is developed and implemented for the first three weeks to guide all staff members. The person centred care plan (PCCP) is developed after three weeks to meet the identified needs and long-term goals of the resident. Short term care plans are not always developed as and when required for acute problems like urinary tract infections. This is area for improvement in 1.3.3.1.

All PCCPs are reviewed every three months and updated when required as sighted. GP reviews are also conducted every three months. The GP interviewed confirms involvement in specialist referrals as well as regular medication reviews. The GP also reported that the clinical staffs always contact the practice regarding any concerns and orders are implemented in a timely and proficient manner.

Continuity of care is maintained as sighted in all eight resident's file sampled. GP entries and visits from allied health providers are sighted. One resident is under the mental health services with regular documented inputs sighted in the resident's file. Daily handovers between staff also ensures continuity of care. During the first day of the audit, an afternoon handover is observed and confirms accurate and comprehensive information are communicated by the RN. HCAs are very involved and participated in the observed handover. They ask questions to clarify issues and other concerns with the RNs. A communication book in each unit is utilised for other resident-related issues like hospital appointments and outings. An integrated system is in place where reports from other allied health providers are sighted e.g. physiotherapist, speech language therapist and podiatrist.

PCCPs are comprehensive and include physical and cultural abilities, deficits and desired/expected outcomes.

Tracer Methodology 1 (rest home level of care)

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

Tracer Methodology 2 (hospital level of care)

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

The relevant ARC requirement D3.1c is not 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.

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 1.3.3.3 (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.

Attainment and Risk: PA Low

Evidence:

Each stage of service provision is provided within time frames that safely meet the needs of the residents. The RNs and CM conduct thorough assessment on admission of a new resident. Initial care plans are created to guide staff in managing the new resident. A person centred care plan (PCCP) is developed after three weeks with the resident and the family as sighted in the documentation. PCCPs are reviewed six monthly as evidence in the eight reviewed files. The HCAs and RNs document the resident's response to treatment in the progress notes. Short term care plans for skin integrity e.g. wounds and fluid/weight losses are developed and evaluated in a timely manner.

Finding:

One resident in the hospital has recurrent urinary tract infections. There is no short term care plan developed for the resident and no evidence of evaluation is sighted in the documentation.

Corrective Action:

Ensure that short term care plans are developed for all acute infections and evaluation must be conducted in a timely manner.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach 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.)

Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

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

Attainment and Risk: FA

Evidence:

The resident's needs, support requirements, and preferences are gathered and recorded in a timely manner. The RNs or the CM completes a number of risk assessment tools on admission i.e. RN assessment, cultural needs, Tinetti risk, mobility, Waterlow, dietary, nutrition/hydration, abbey pain, continence and oral. Additional assessments sighted in the reviewed resident's file include the medical assessment completed by the GP and recreational assessment completed by the diversional therapist. Baseline recordings are also recorded on admission, and there after monthly recordings are sighted including weights. Families/residents are involved in the assessment process. The outcomes of the assessments are utilised by the RNs or CM in developing an initial plan of care as well as long term care plan.

The relevant ARC requirements are met.

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

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.

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 1.3.5: Planning (HDS(C)S.2008:1.3.5)

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

Attainment and Risk: FA

Evidence:

Care plans are resident focused, integrated, and promote continuity of service delivery. An initial plan of care is developed on admission while long term care plans which are called person centred care plans (PCCP) are developed within three weeks from admission. The facility uses an integrated system i.e. GP writes in his section while

the RNs, diversional therapist, physiotherapist and other visiting allied members write in the care notes. The residents file currently has sections for PCCP, monitoring, risk assessments, event logs, GP, laboratory, allied health, consents and NASC. Interventions sighted are consistent with assessed needs and best practice. The required level of dependence is documented in each goal. The desired outcomes are realistic and achievable. Short term care plans for weight loss and watery stools are sighted but no short term care plans for acute infections are sighted. Please refer to 1.3.3.3.

The relevant ARC requirements are met.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

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

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 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

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 1.3.6: 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 in order to meet their assessed needs and desired outcomes. Interventions are documented for each goal on the PCCP. Interventions sighted are commensurate with current needs and sufficiently detailed to address the needs of the residents. The GP who started four months ago is satisfied that clinical interventions are based on good practice and implemented in a timely and competent manner. For example, a resident with suspected scabies confirms good success with identifying and treating the skin condition. GP and nursing collaboration effectively managed the identified problem. The weekly to monthly frequent GP visits and the regular blood tests are conducted to rule out other possible issues e.g. communicable disease.

Interventions from allied health providers are also included in the care planning. For example, speech language therapists input on a resident with choking episodes as well as from the mental health service from the DHB are sighted in the residents file reviewed.

Residents and families are encouraged to be involved in developing the PCCP goals and desired outcomes. Meetings are conducted by the CM to discuss the PCCP in order to develop realistic plans in order to meet optimal levels of functioning of the resident. All eight PCCP sighted are all signed by either the resident or by their families.

The relevant 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:

There is one qualified diversional therapist (DT) who works full-time Monday to Friday. The DT has been employed by the service since February 2013 and has six years of experience working in aged care. The DT also attends regular education and training provided by the organisation and externally as well as receiving specialised training on the Eden Alternative™, a programme dedicated to bringing meaning and fulfilment to the lives of the elderly. The DT holds a current CPR and first aid certificate and is a qualified New Zealand Qualifications Authority (NZQA) assessor.

Over the course of this audit, residents were observed being actively involved with a variety of activities. The programme is developed each month with weekly plans distributed to the residents and posted in the hallways. This includes monthly outings.

The DT completes the recreation assessment for each resident, which identifies personal interests and hobbies to ensure participation in the activities provided in the facility. There is no individual activities plan for all eight resident's file sampled. This is an area for improvement in 1.3.7.1. A monthly review is sighted in the progress notes of the eight out of eight resident's file sampled as well as three monthly reviews through a multidisciplinary review (MDR) meeting.

A range of activities is available to residents and includes one-on-one time with residents who are unable or do not wish to participate with group activities. A recent resident satisfaction survey (November 2013) has identified several opportunities for improvements relating to activities although this was not a trend that was identified during the audit. Resident and family interviews confirm they are satisfied with the activities programme. To date, the acting facility manager has been meeting with the clinical coordinator and diversional therapist about a quality improvement plan relating to activities.

The activities programme provided at West Harbour Lodge is of a high standard and reflects that independence is encouraged and choices are offered. The activities are appropriate to the resident's needs, age, culture and the level of care provided. The diversional therapist (DT) coordinates the programme and is on site five days per week. Two part-time activities assistants and a community volunteer support the DT in implementing the activities programme. A range of several relevant resources are sighted and is accessible for all staff. The craft room showcases the "works" of the residents.

Residents interviewed speak highly regarding the variety of activities and three weekly outings that are planned and offered in the facility. Preferences are considered and interests are maintained. The DT reported that outings are well-enjoyed by the residents. The facility has a new van with wheelchair accessibility. Residents can also access the community independently and continue with their personal interests.

ARC requirement D16.5c.iii is not 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:

The activities programme provided in the facility is of a high standard and reflects that independence is encouraged and choices are offered. The diversional therapist (DT) coordinates the programme and is on site five days per week. Two part-time activities assistants and a community volunteer support the DT. A range of several

relevant resources are sighted and is accessible for all staff. The DT ensures that weekly activities are communicated to all residents via flyers and signage's in the activities board i.e. main entrance and in both rest home and hospital units. The craft room which is in the rest home unit showcases the "works" of the residents. Activities are conducted in the lounge which accommodates both rest home and hospital residents, even the less mobile residents.

Residents interviewed speak highly regarding the variety of activities and three weekly outings that are planned and offered in the facility. Preferences are considered and interests are maintained. The DT reports that outings are well-enjoyed by the residents. Residents can also access the community independently and continue with their personal interests.

Finding:

All eight out of eight residents file sampled have no activity plan in place, although monthly reviews are sighted in the progress notes.

Corrective Action:

Ensure that all residents will have an individual activity plan in place.

Timeframe (days): 60 (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:

Eight out of eight PCCPs of the residents file sampled have three monthly reviews, as per care planning policy. Reviews are documented on the MDR forms which include inputs from the GP, RNs, HCAs, DT and other members of the allied health team. Daily progress notes are completed by the HCAs and RNs which assess daily response to interventions or treatments. Any changes to support the interventions are documented to enable the resident to attain their goals or to work towards goals if not clearly attained. Short term care plans i.e. skin, fluid loss are also evaluated as required. Additional reviews include the three monthly medication reviews by the GP as well as mental health services reviews are sighted.

Please refer to 1.3.3.3 regarding short term care plan not developed for UTI.

The relevant 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

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

Attainment and Risk: FA
Evidence:
<p>The GP and CM interviewed stated that resident support for access or referral to another health and disability provider is facilitated in a timely and proficient manner. The RNs or the CM refers residents for further management to the GP, dietician, physiotherapist, speech language therapist and mental health services in the DHB. A food supplement company provided in-service training last December 2013 for all staff regarding thickeners and other food supplements. They also access the CARE team for emergency mental health issues. The GP confirms his involvement in the referral process.</p> <p>A formal referral process exists which involves identification of risk and involvement of family when required. Evidences of recent referrals are included in the sample. Referrals are kept in the resident's files as sighted.</p> <p>The relevant ARC requirements are met.</p>

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

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.

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

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

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

ARC D21 ARHSS D21

Attainment and Risk: FA
Evidence: <p>Planned discharges or transfers are conducted in collaboration with the resident and family (if available) to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The CM reported that the yellow envelop is utilised and considered useful when sending a resident to and from the hospital.</p> <p>In the event of a discharge or transfer to another provider, the resident's records are copied including GP visits, medication charts, PCCPs, upcoming hospital appointments and other medical alerts. A resident transfer form is completed by the RN or CM in the event of transfers or discharges.</p> <p>The relevant ARC requirements are met.</p>

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

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.

Attainment and Risk: FA
Evidence:

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

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: PA Low

Evidence:

Residents receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. Five medicines are crushed without appropriate documentations or guidance from either the pharmacy or from the GP. This is an area for improvement in 1.3.12.1. The clinical and quality manager (CQM) communicated to the CM via a memo that all crushed medications must not be administered to residents unless approved by the pharmacy and GP. This memo was not implemented accordingly but the CM ensures that the RNs will only crush medication after receiving guidelines from the pharmacy and with the approval of the GP. During the day of the audit, the CM was able to obtain guidelines from the pharmacy. The GP also confirms that he is documenting the crushed medications in the resident's files accordingly. The pharmacy will clearly identify in the medication chart the medications that can be crushed. RNs are also reminded during the afternoon handover that medications can only be crushed after having the guidelines from the pharmacy and documentation by the GP.

A robotics medication system is implemented. All medicines are prescribed by the GP using pharmacy generated medication charts. The facility has one prescribing GP for medical needs and support. Additional medications are prescribed by the appropriate authority e.g. psychiatrist. All medication charts include current photos and allergies. Three monthly reviews are evident in all 16 medication charts reviewed.

Medication reconciliation policies and procedure is implemented in the facility. The RNs or CM check the medications of residents on entry to the facility. This includes blister packs, robotic, non-packed medications and injectable. Both packed and non-packed medications are safely stored in the two medication room, one for each unit. A medication fridge in the hospital unit contains insulin vials. There is a small locked metal box inside the hospital medication room to store controlled drugs. The required drug checks of controlled drugs are evident, including the six monthly check conducted by the pharmacy. There are no illegal erasures sighted or unsigned areas in the sighted controlled drugs register. The facility utilise two controlled drugs registers, one for daily controlled drugs and one for PRN liquid controlled drugs. A calibrated measuring cylinder is purchased to obtain an actual measurement of the liquid controlled drugs during stocktake. Two fridges are monitored weekly by the RNs as evidence in the medication room. The values are within the acceptable temperature range. A sharps bin is sighted in each medication room.

All medications are labelled and dated per resident. All unwanted or expired medications are collected by the pharmacy staff regularly. A pharmacy returns policy and procedure is in place and implemented. Pharmacy returns folder is sighted during the medication room check. The expired medications are kept inside the cupboard inside a box and removed from circulation to avoid accidental usage.

Medications are administered by staff assessed as competent. Competencies for medicine management and administration are monitored by the facility manager (FM) and clinical manager (CM). Records are sighted to verify the process and a lunchtime medication rounds are observed in each unit by the RNs which confirms administration is safely maintained as per medicine policies and procedures. The RNs interviewed are knowledgeable about the administered medicines and side-effects.

There are seven residents who are self-administering inhalers. Self-administration competencies are sighted for all seven residents and three monthly GP reviews are evident. The CM reported that staff check the residents every shift to ensure that the inhalers are used. The inhalers are kept in a lockable cupboard as per policy.

ARC requirements D1.1g and D19.2d are not 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: PA Low

Evidence:

Residents receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. A robotics medication system is implemented. All medicines are prescribed by the GP using pharmacy generated medication charts. The facility has one prescribing GP for medical needs and support. Additional medications are prescribed by the appropriate authority e.g. psychiatrist. All medication charts include current photos and allergies. Three monthly reviews are evident in all 16 medication charts reviewed.

Medication reconciliation policies and procedure is implemented in the facility. The RNs or CM check the medications of residents on entry to the facility. This includes blister packs, robotic, non-packed medications and injectable. Both packed and non-packed medications are safely stored in the two medication room, one for each unit. A medication fridge is in the hospital unit that contains insulin vials. There is a small locked and metal box inside the hospital medication room to store controlled drugs. The required drug checks of controlled drugs are evident, including the six monthly check conducted by the pharmacy. There are no illegal erasures sighted or unsigned areas in the sighted controlled drugs register. The facility utilise two controlled drugs register, one for daily controlled drugs and one for PRN liquid controlled drugs. A calibrated measuring cylinder is purchased to obtain an actual measurement of the liquid controlled drugs during stocktake. Two of the two fridges are monitored weekly by the RNs as evidence in the medication room. The values are within the acceptable temperature range. A sharps bin is sighted in each medication room.

All medications are labelled and dated per resident. All unwanted or expired medications are collected by the pharmacy staff regularly. A pharmacy returns policy and procedure is in place and implemented. Pharmacy returns folder is sighted during the medication room check. The expired medications are kept inside the cupboard inside a box and removed from circulation to avoid accidental usage.

Finding:

Five medicines are crushed without appropriate documentations or guidance from either the pharmacy or from the GP. The clinical and quality manager (CQM) communicated to the CM via a memo that all crushed medications must not be administered to residents unless approved by the pharmacy and GP. This memo was not implemented accordingly but the CM ensures that the RNs will only crush medication after receiving guidelines from the pharmacy and with the approval of the GP. During the day of the audit, the CM was able to obtain guidelines from the pharmacy. The GP also confirms documenting the crushed medications in the resident's files accordingly. RNs are also reminded during the afternoon handover that medications can only be crushed after having the guidelines from the pharmacy and documentation by the GP.

Corrective Action:

Ensure that guidelines are obtained and systems are implemented regarding crushing of medications.

Timeframe (days): 7 (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.

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 1.3.13: 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

Attainment and Risk: FA

Evidence:

The resident's individual food, fluids and nutritional needs are met. Residents are provided with a well-balanced diet which meets their cultural and nutritional requirements. The meals are prepared and cooked onsite. The summer and winter menus are reviewed by the dietician last September 2013. The menu review is based on nutritional guidelines for the older people in the long-term care. A dietary assessment is completed by the RNs or CM on admission and this information is shared with kitchen staff to ensure all needs, food allergies, likes, dislikes and special diets e.g. diabetic, vegetarian are catered for. The facility also provides modified diets e.g. puree diets to meet the dietary requirements of the residents. The RNs or CM requires the cook to sign the dietary assessment and keeps a copy of that signed dietary form in the kitchen folder. A white board in the kitchen also contains important "alerts" for all staff working in the kitchen e.g. dislikes and allergies. The HCAs manage the additional food supplements prescribed for the residents (e.g. Fortisip, Ensure).

The cook is interviewed and manifests good knowledge of the kitchen routines and documentation requirements. Nutrition and safe food management policies define the requirements for all aspects of food safety. The uses the first in-first out system for the stocks. The kitchen and pantry is sighted and is clean, well-stocked and tidy. A kitchen cleaning schedule is in place and implemented. Labels and dates on all containers and records of food temperature monitoring are maintained. The chiller, fridge and two freezer temperatures are monitored three times a day and evidences are sighted and are within the acceptable temperature ranges.

The cook and the two kitchen assistants have current food handling certificates.

During meal preparation, the cook and kitchen assistant are wearing disposable hats, gloves and aprons. All HCAs serving the lunchtime meals are also wearing disposable hats. Meals are plated in the hospital and rest home dining areas which shows good presentation to entice appetite and sufficient in quantity.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. All foods in the freezer and chiller are in their original packaging and are labelled and dated if not in the original packaging.

Two residents reported during interview that they love the variety of food provided by the facility. Family members mentioned that the servings are adequate and very presentable.

The relevant ARC requirements are met.

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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.

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.)

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 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

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

Attainment and Risk: FA

Evidence:

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staffs receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

The provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by staff. During a tour of the facility protective clothing and equipment was observed in all high risk areas.

Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. Infection control policies state specific tasks and duties for which protective equipment is to be worn.

ARC requirements are met.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

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.

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 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

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 1.4.2: 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: FA

Evidence:

A current Building Warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 14 December 2014). There have been no buildings modifications since the last audit however there are room refurbishments in progress for two rooms.

There is a planned maintenance schedule implemented.

The lounge areas are designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounges on the day of the audit.

The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programmes two yearly and this is up to date.

Interviews with five of five caregivers, two registered nurses and the clinical manager confirmed there is adequate equipment.

There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required.

There are safe outside areas that is easy to access for residents and family members.

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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.)

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

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

Attainment and Risk: FA

Evidence:

There are adequate numbers of accessible toilets/bathing facilities. This includes full ensuites, visitors, toilets and communal toilets conveniently located close to communal areas.

Communal toilet facilities have a system that indicates if it is engaged or vacant noting that these were put in for some communal toilets and showers on the day of the audit.

Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

Nine residents (eight rest home and one hospital) and eight family members (five hospital and three rest home) interviewed report that there are sufficient toilets and showers with a number of rooms having their own ensuite.

ARC requirements are met.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

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.

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 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

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

Attainment and Risk: FA

Evidence:

There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.

Equipment was sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff and the resident. Residents requiring use of a hoist were sighted on the day with staff supporting them in their rooms with sufficient space for all.

Rooms can be personalized with furnishings, photos and other personal adornments.

There is sufficient room to store mobility aids such as walking frames in the bedroom safely during the day and night if required and a bay for mobility scooters.

ARC requirements are met.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

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.

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 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

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

Attainment and Risk: FA

Evidence:

The service has two lounge/dining areas (one in the rest home and one in the hospital area) each with a kitchenette and these are large with appropriate floor coverings in

each part e.g. carpet only in the lounge area of the room. All areas are easily accessed by residents and staff.
Residents are able to access areas for privacy if required.
Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.
The lounges are also accessible lounge which is used for activities and a specific area for the hairdresser is located in the hospital area.
ARC requirements are met.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

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

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

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

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

Attainment and Risk: FA
Evidence: <p>Laundry is subcontracted to a service and is independent to West Harbour Lodge. Nine residents (eight rest home and one hospital) and eight family members (five hospital and three rest home) state that the laundry is well managed and they get back their clothes. One family states that some clothes come back creased with harsh chemicals used.</p> <p>There are two cleaners on site during the day seven days a week. The cleaners were observed to have the trolley in the room with them when cleaning and all had appropriately labelled containers. Ecolab products are used with training around use of products last provided in May 2013.</p> <p>Cleaning is monitored through the internal audit process with no issues identified in audits last completed in April and October 2013.</p> <p>Chemicals and cleaning cupboards are locked.</p> <p>ARC requirements are met.</p>

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

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

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

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

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

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

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

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

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

Attainment and Risk: FA
Evidence: An evacuation plan was approved by the New Zealand Fire Service on 28 June 2010. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly with the last drill conducted in January 2014. The orientation programme includes fire and security training. Staff confirm their awareness of emergency procedures.

There is always one staff member at least with a first aid certificate on duty – confirmed through review of the roster and confirmed by the business and care manager. All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. A back up battery for emergency lighting is in place. An electronic call bell system utilises a pager system. There are call bells in all residents' rooms, residents' toilets, and communal areas including the hallways, dining room and hairdressing space. Call bell audits are routinely completed. The doors are locked in the evenings doors can only be opened from the inside. Systems are in place to ensure the facility is secure and safe for the residents and staff. External lighting is adequate for safety and security with sensor lights on the outside of the building. ARC requirements are met.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

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

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 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation 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.)

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

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

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

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

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

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

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 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

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

Attainment and Risk: FA

Evidence:

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.

Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.

ARC requirements are met.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

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

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 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

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

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

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

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: FA
Evidence: <p>West Harbour Lodge uses restraints and enablers. Restraint use is actively minimised and the restraints used are lap belts and bedrails. There are currently eight residents on restraint e.g. six bedrails, one bedrail as an enabler and one lap belt. The file reviewed of the one resident who uses a bedrail as an enabler is voluntary and the least restrictive option for the resident. Restraint minimisation policies and procedures are implemented in practice. There are no restraint-related injuries reported. All bedrails have specialised bedrail covers when in use as part of the risk management plan. HCAs are completing restraint monitoring forms as sighted.</p> <p>A documented system is in place for restraint e.g. restraint/enabler assessment and evaluation forms, consent forms, authorisation and plans forms. Reasons why a restraint is considered including safety, medical and security considerations are noted. Sensor mats are in place to manage residents on restraints. Three monthly restraint reviews are evident. Definitions are congruent with requirements of the HDSS standards and staffs interviewed are aware of the correct definitions. Restraint competencies are sighted and current. There are guidelines in place in managing challenging behaviour. Staffs receive adequate training as per education planner. An</p>

annual education log for facilities is sighted with restraint management and minimisation training due on April 2014 which will be conducted by the restraint coordinator.

The restraint register sighted is current and updated accordingly by the restraint coordinator.

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: 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.)*

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

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

Attainment and Risk: FA

Evidence:

The facility maintains a process for determining approval of all types of restraint used. The restraint coordinator completes a restraint assessment prior commencing any restraint and discusses this with the GP and the family or resident. The restraint approval group is defined in the restraint minimisation and safety policies and procedures. The duration of the restraint is documented in the restraint plan. HCAs are responsible in monitoring and completing restraint forms when the restraint is in use. Evidence of ongoing education is evident in September 2013. Staffs are made aware of the residents on restraints during monthly staff meetings. The restraint in-service training is scheduled on 8-April 2014.

ARC requirements are met.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

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

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

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

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

Attainment and Risk: FA
Evidence: <p>The restraint coordinator is one of the RNs and ensures that rigorous assessment of the resident is undertaken in relation to the use of restraint. The restraint coordinator completes a restraint assessment form prior commencing a restraint. Risk management plan is created to ensure the safety of the resident and to guide the HCS and RNs in managing the restraint in place. Desired outcomes are defined in the risk management plan as sighted.</p> <p>The relevant ARC requirements are met.</p>

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

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.

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

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

Attainment and Risk: FA
Evidence: <p>The facility uses restraint safely. Before resorting to the use of restraint, the restraint coordinator utilise other means to prevent the resident from having injury e.g. low beds, mattresses and sensor mats. If not adequate to manage the resident's risk of falling or having injury, the restraint coordinator commences restraint after following the restraint minimisation policies and procedures. Authorisations are sighted and signed by the GP, family/resident and the restraint coordinator. The use of restraint is monitored by the HCAs as sighted. Restraint is incorporated in the PCCP and are reviewed three monthly. There are currently no restraint-related injuries reported by the CM during interview.</p> <p>The sighted restraint register is current with the dates commencing and ending the restraint is noted.</p> <p>The relevant ARC requirements are met.</p>

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

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.

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

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

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.

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 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

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

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 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA
Evidence: <p>The restraint coordinator evaluates all episodes of restraint. PCCPs are evaluated three monthly including the effectiveness of the restraint in use, restraint-related injuries and required changes if needed. The family/resident (if able) is included in the evaluation of the restraints effectiveness and continuity. Documentations are also sighted in the progress notes of the residents on restraint. The CM reported that the restraint coordinator evaluates if the restraint minimisation policies and procedures are implemented and followed by all staff.</p> <p>The relevant ARC requirement is met.</p>

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

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.

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

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

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.

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

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

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

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

Attainment and Risk: FA

Evidence:

The facility demonstrates the monitoring and quality review of their use of restraint. Quality audit schedule is sighted and restraint minimisation is reviewed on July 2013. The content of the internal audit include effectiveness of restraint, staff compliance to the policies and procedures, safety and cultural considerations of the restraint used, staff knowledge and good practice in the use of restraint and restraint-related/adverse outcomes while the resident is on restraint.

The relevant ARC requirements are met.

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

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.

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

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

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

Attainment and Risk: FA

Evidence:

West Harbour Lodge's infection control programme is clearly documented and is suitable for the facility as well as the level of care provided. The infection control programme is reviewed annually. There is a designated infection control leader and the committee is composed of three HCAs, one kitchen staff and one cleaner. The infection control leader's responsibilities are clearly documented and signed on April 2012. Interview with the infection control leader indicates that all infections are monitored through a surveillance system using an infection log i.e. infection type, signs and symptoms, date the infection started and resolved.

The committee conducts a monthly meeting with the agenda sighted. Staff hand washing competencies are conducted on 07-March 2013 on 45 staff. The infection control in-service training on hand washing, waste policy, blood/body fluids, accident notifications and sharps was held last September 2013. The infection control-standard precautions in-service training will be held on May 2014.

Staff, families and visitors who are suffering from or exposed to and susceptible to, infectious diseases are prevented from exposing others while infectious. Staffs are encouraged to use their sick days and ensure that the signs and symptoms are no longer present before reporting for work. Hand sanitisers are available when and after visiting the relatives in the facility.

The relevant ARC requirements are met.

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

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.

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 3.1.3 (HDS(IPC)S.2008:3.1.3)

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

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 3.1.9 (HDS(IPC)S.2008:3.1.9)

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.

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 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

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

Attainment and Risk: FA

Evidence:

One of the RNs is the designated infection control leader and the committee is composed of three HCAs, one kitchen staff and one cleaner. Interview with the infection control leader indicates that all infections are monitored through a surveillance system using an infection log i.e. infection type, signs and symptoms, date the infection started and resolved. Staff hand washing competencies are conducted on 07-March 2013 on 45 staff. There is adequate hand washing equipment in the facility. The infection control leader serves as a resource person having level seven qualifications in infection control and has access to current information relevant to the size and complexity of the facility. Staff can access infection control manuals, expert advice from the DHB or laboratory.

The relevant ARC requirements are met.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

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.

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 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

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

Attainment and Risk: FA

Evidence:

Documented policies and procedures are in place for the prevention and control of infection in the facility. The policies are appropriate for the size of the facility and reflect

current accepted good practice and legislative requirements. Policies and procedures are written in a user-friendly format and contain appropriate level of information. These are reviewed annually in consultation with relevant members of the quality team. Policies are accessible to staff in service areas e.g. nurse's station.

The relevant ARC requirements are met.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

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

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 3.4: Education (HDS(IPC)S.2008:3.4)

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Infection control education is included in the orientation programme for new staff and again in an ongoing manner as part of training diary. The orientation training is provided by the CM or infection control leader while external trainings are provided by the DHB during study days for RNS and HCAs. The infection control leader has level seven qualifications in infection control.

Staff hand washing competencies are conducted on 07-March 2013 on 45 staff. The infection control in-service training on hand washing, waste policy, blood/body fluids, accident notifications and sharps was held last September 2013. The infection control-standard precautions in-service training will be held on May 2014. Evaluations are conducted after the in-service training as evidence in the infection control folder.

The relevant ARC requirements are met.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

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

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

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

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.

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

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 surveillance programme is appropriate for the size of the facility and the level of care provided. The use of antibiotics is monitored and infection rates are graphed to enable useful analysis. The infection control leader conducts the surveillance and provides the CM with data who then enters these collected data for

benchmarking. Additional data includes signs and symptoms, classification of infection and outcomes. Surveillance data is collected monthly by the infection control leader. When a preventative response or corrective action is required, it is recorded and implemented. This is evident in the records regarding the management of suspected scabies in the rest home unit. Two staff interviewed report they are made aware of the infection rates in the facility and of any individual with infection via the monthly staff meetings and handovers. The GP is also informed when a resident has an infection and prescribes the appropriate antibiotics as per sensitivity. ARC requirements are met.

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.)