

Oceania Care Company Limited - Dunblane Lifestyle Care & Village

Current Status: 18 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

Dunblane provides residential care for up to 75 residents who require rest home, hospital and dementia level care. The occupancy on the day of the audit was 50. Dunblane is operated by Oceania Care Company Ltd and is situated in Gisborne. This certification audit was undertaken to monitor compliance with specified requirements of the Health and Disability Services Standards and the District Health Board contract.

The service employs 64 staff members. The service is provided from one site. The audit included reviewing of staff and resident records, interviews with residents, their family members and staff.

There are two areas identified as requiring improvement at this audit relating to medicine management and long term care planning.

Audit Summary as at 18 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
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

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

Consumer Rights as at 18 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 18 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.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 18 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 18 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 18 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 18 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 18 March 2014

Consumer Rights

Residents are informed of their rights, privacy and are familiar with the consent and complaints processes. Consumer rights information is available to all residents and their families.

Staff members receive training regarding the rights of residents, including cultural awareness training and are responsible for implementing these rights. Residents' needs, including the need for an interpreter or advocate are recorded and provided for.

Consent forms, a copy of the resident rights and the complaints process are included in the admission pack for all residents on admission. Staff members wear name badges to facilitate easy identification. The service maintains a current complaints register.

Organisational Management

The service is managed by an experienced facility manager who is assisted in her position by the clinical manager who is a registered nurse.

The resident information is uniquely identified, current, confidential and accessible. The service uses a multidisciplinary approach employing clinical and administrative staff to ensure service continuity.

The strategic, business and quality and risk plan are based on the vision, mission and philosophy of Oceania Care Group. The facility manager reports to the Oceania Care Group support office on a monthly basis.

The quality and risk management system includes an internal audit programme. Quality improvement data is collected, collated, and analysed to identify trends. Corrective actions are developed and implemented, when required. Reporting of quality improvement data occurs via scheduled staff meetings, quality and other meetings.

Annual practising certificates are current for all staff who require it to practice. Staff education is planned and conducted and this is recorded in staff files.

The service has a documented rationale for determining staffing levels and staff skill mixes. The facility manager and the clinical manager who is a registered nurse work Monday to Friday and are available after hours if required. Care staff interviewed report there is adequate staff available to perform their duties.

Continuum of Service Delivery

Entry into the service is facilitated in a competent, timely and respectful manner. When referral/entry to the service is declined, immediate risks are identified. The initial care plan is utilised as a guide for all staff while the person centred care plan is developed over the first three weeks. Care plans are individualised and risk assessments are completed. Resident's response to treatment is evaluated and documented accordingly. Care plans are evaluated six monthly. Tracer methodology was carried out for the rest home, hospital and dementia units.

Activities are appropriate to the age, needs and culture of the residents and support their interests and strengths. The residents and families interviewed express high satisfaction with the activities provided by the diversional therapists. Relatives are notified regarding changes in a resident's health condition.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. Fourteen medication charts are reviewed.

The facility utilises four weekly rotating summer and winter menus and are reviewed by a dietician. The next review is planned for August 2014.

Safe and Appropriate Environment

There is a current building warrant of fitness and the service has documented systems for essential, emergency and security services. The service has a proactive maintenance programme which includes hot water temperatures monitoring, fridge and freezer temperature monitoring, general maintenance and emergency evacuation and first aid training for staff.

Restraint Minimisation and Safe Practice

The facility actively practices restraint minimisation and safe practice. The restraint minimisation programme defines the use of restraints and enablers. The restraint register is current and key points regarding risk assessment, documentation, monitoring, maintaining care, and reviews are identified and implemented in practice. Policies and procedures comply with the standard for restraint minimisation and safe practice. Residents on restraints have no restraint-related injuries. Staff receive adequate training regarding the management of challenging behaviour and restraint use.

Infection Prevention and Control

The infection control programme is reviewed annually for its continuing effectiveness and appropriateness for the facility. Staff education in infection prevention and control is conducted as per education and training record. Infections are investigated and appropriate antibiotics are prescribed per sensitivity. The surveillance data are collected monthly for benchmarking and appropriate interventions are put in place to address the infections. There are adequate gels and hand washing facilities for staff, visitors and residents. Staff are able to explain how to break the chain of infection.

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 - Dunblane Lifestyle Care & Village
Designated Auditing Agency:	Health Audit (NZ) Limited
Types of audit:	Certification Audit
Premises audited:	Dunblane Lifestyle Care & Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 March 2014 End date: 19 March 2014
Proposed changes to current services (if any):	
	None
Total beds occupied across all premises included in the audit on the first day of the audit:	50

Audit Team

Lead Auditor	XXXXX	Hours on site	16	Hours off site	8
Other Auditors	XXXXX	Total hours on site	16	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	XXXXXX			Hours	4

Sample Totals

Total audit hours on site	32	Total audit hours off site	16	Total audit hours	48
Number of residents interviewed	7	Number of staff interviewed	12	Number of managers interviewed	3
Number of residents' records reviewed	7	Number of staff records reviewed	8	Total number of managers (headcount)	3
Number of medication records reviewed	14	Total number of staff (headcount)	64	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	2

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, 31 March 2014

Executive Summary of Audit

General Overview

Dunblane provides residential care for up to 75 residents who require rest home, hospital and dementia level care. The occupancy on the day of the audit was 50. Dunblane is operated by Oceania Care Company Ltd and is situated in Gisborne. This certification audit was undertaken to monitor compliance with specified requirements of the Health and Disability Services Standards and the District Health Board contract.

The service employs 64 staff members. The service is provided from one site. The audit included reviewing of staff and resident records, interviews with residents, their family members and staff.

There are two areas identified as requiring improvement at this audit relating to medicine management and long term care planning.

Outcome 1.1: Consumer Rights

Residents are informed of their rights, privacy and are familiar with the consent and complaints processes. Consumer rights information is available to all residents and their families.

Staff members receive training regarding the rights of residents, including cultural awareness training and are responsible for implementing these rights. Residents' needs, including the need for an interpreter or advocate are recorded and provided for.

Consent forms, a copy of the resident rights and the complaints process are included in the admission pack for all residents on admission. Staff members wear name badges to facilitate easy identification. The service maintains a current complaints register.

Outcome 1.2: Organisational Management

The service is managed by an experienced facility manager who is assisted in her position by the clinical manager who is a registered nurse.

The resident information is uniquely identified, current, confidential and accessible. The service uses a multidisciplinary approach employing clinical and administrative staff to ensure service continuity.

The strategic, business and quality and risk plan are based on the vision, mission and philosophy of Oceania Care Group. The facility manager reports to the Oceania Care Group support office on a monthly basis.

The quality and risk management system includes an internal audit programme. Quality improvement data is collected, collated, and analysed to identify trends. Corrective actions are developed and implemented, when required. Reporting of quality improvement data occurs via scheduled staff meetings, quality and other meetings.

Annual practising certificates are current for all staff who require it to practice. Staff education is planned and conducted and this is recorded in staff files.

The service has a documented rationale for determining staffing levels and staff skill mixes. The facility manager and the clinical manager who is a registered nurse works Monday to Friday and is available after hours, if required. Care staff interviewed report there is adequate staff available to perform their duties.

Outcome 1.3: Continuum of Service Delivery

Entry into the service is facilitated in a competent, timely and respectful manner. When referral/entry to the service is declined, immediate risks are identified. The initial care plan is utilised as a guide for all staff while the person centred care plan is developed over the first three weeks. Care plans are individualised and risk assessments are completed. Resident's response to treatment is evaluated and documented accordingly. Care plans are evaluated six monthly. Tracer methodology was carried out for the rest home, hospital and dementia units.

Activities are appropriate to the age, needs and culture of the residents and support their interests and strengths. The residents and families interviewed express high satisfaction with the activities provided by the diversional therapists. Relatives are notified regarding changes in a resident's health condition.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. Fourteen medication charts are reviewed.

The facility utilises four weekly rotating summer and winter menus and are reviewed by a dietician. The next review is planned for August 2014.

Outcome 1.4: Safe and Appropriate Environment

There is a current building warrant of fitness and the service has documented systems for essential, emergency and security services. The service has a proactive maintenance programme which includes hot water temperatures monitoring, fridge and freezer temperature monitoring, general maintenance and emergency evacuation and first aid training for staff.

Outcome 2: Restraint Minimisation and Safe Practice

The facility actively practices restraint minimisation and safe practice. The restraint minimisation programme defines the use of restraints and enablers. The restraint register is current and key points regarding risk assessment, documentation, monitoring, maintaining care, and reviews are identified and implemented in practice. Policies and procedures comply with the standard for restraint minimisation and safe practice. Residents on restraints have no restraint-related injuries. Staff receive adequate training regarding the management of challenging behaviour and restraint use.

Outcome 3: Infection Prevention and Control

The infection control programme is reviewed annually for its continuing effectiveness and appropriateness for the facility. Staff education in infection prevention and control is conducted as per education and training record. Infections are investigated and appropriate antibiotics are prescribed per sensitivity. The surveillance data are collected monthly for benchmarking and appropriate interventions are put in place to address the infections. There are adequate sanitary gels and hand washing facilities for staff, visitors and residents. Staff are able to explain how to break the chain of infection.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	48	0	2	0	0	0
Criteria	0	98	0	2	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	1

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	The interventions in eight out of ten PCCPs sighted are not adequate to support the goals/desired outcomes to address the needs of the residents.	Ensure that the planned interventions are sufficiently detailed to address the needs of the residents.	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	PA Low	The EN/RN report that seven medications are crushed without adequate documentation or guidelines from the GP or from the	Ensure that crushed medications are supported by adequate documentation and guidelines to comply with the current medication legislation.	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		medicine reconciliation in order to comply with legislation, protocols, and guidelines.		<p>pharmacist.</p> <p>There are 5 out of 14 medication charts block signed, ditto signed, not dated or no year written on it.</p>	Ensure that all medications are individually dated and signed by the GP.	

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: During interview the staff members confirm they understand the rights and their obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The service offers training to staff members and residents regarding the Code. Staff training occurred on 28 February and 28 November 2013. Residents received training after the satisfaction survey in August 2013. The service has brochures and information on the Code available as part of the admission pack. 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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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:

Staff allow opportunity for explanation, discussion clarification of the Code during admission of residents and the manager completes annual training with the residents regarding the content of the Code and how it applies to the resident. The residents then again receive information brochures and pamphlets and there is discussion of the Code, sighted the training content. Residents interviewed agree they are informed of their rights. The Code is displayed at the entrance and in the different areas of service throughout the service.

The information about the Nationwide Health and Disability Advocacy Service is included in the resident and staff training days.

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
<p>Evidence:</p> <p>Staff are observed knocking on doors before entering the rooms of residents. Needs, values and beliefs are discussed with the residents during the assessment process and are incorporated into the person centered care plan (PCCP). Preferred names are documented and residents confirm they have access to visitors of their choice. Policies and staff code of values and conduct are in place for prevention of abusive or neglectful behaviour.</p> <p>All residents have single rooms and there are several rooms with an ensuite. Locked cupboards are available to secure valuables. The assessment process determines and documents any requirements the resident may have in regards to meeting their needs, values and beliefs. The resident care pathway is changed where necessary to ensure all needs are met.</p> <p>Seven of the seven residents interviewed agreed their preferred name is used and they are treated with respect. Spiritual beliefs are documented in all of clinical records sighted. All visitors are welcomed. A policy is in place for the guidance of staff in the event of a resident advising the staff of any advanced directives they may have. Resident rights education for staff includes the issues of abuse and neglect. ARC requirements are met.</p>

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

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:
<p>The service has systems that ensure the values and beliefs of patients who identify as Maori are met. There is a documented Maori Health Plan policy that has been developed at support office. The service has access to a kaumatua for blessing of rooms, church services and functions. Cultural safety staff education sessions for staff are held annually. Staff interviewed are aware of protocols and information sources. Maori staff who identify as Maori are available to support Maori patients if required. Sixty per cent of the current staff are of Maori decent. There are currently eight residents who identify as Maori in the service.</p> <p>Information is available about local advocacy services that include support for Maori. Sighted documented resources for appropriate service delivery to Maori residents and whanau. Documented policies relating to the return / disposal of body parts / tissues and for management of deceased residents include cultural guidelines for Maori. The importance of whanau is described as one of the principles of the provision of health services to Maori. Maori staff are involved in the quality review process. ARC requirements are met.</p>

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

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

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

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:

Policies are in place to ensure staff are guided in the provision of culturally safe care. The resident assessment process determines individual values and beliefs and the provision of care is modified accordingly where required. Cultural awareness policies and procedures are in place. Cultural and individual values are determined during the admission process by each resident or their family contributing to the health questionnaire completed by the registered nurses outlining any specific requirements.

The resident satisfaction survey of August 2013 indicates satisfaction with the way that individual cultural needs have been met. There is evidence from resident interviews and in their records that they are consulted at all stages of their care. Involvement is seen in the completed documentation, during the admission and assessment process, the gaining of consent and the planning and evaluation of care. The RN's and facility manager confirm these processes during interview.

ARC requirements are met.

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

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:

Policies and staff education on resident rights including freedom from discrimination and exploitation are in place. The policies are included in the Code of Values and Conduct and the Oceania Care Group / NZNO Collective Agreement or their Individual Employment Agreement. Six of six health care assistants interviewed demonstrated understanding of these issues. Results of resident surveys indicate satisfaction with the manner in which services have been delivered to them. Professional behaviour is directed by the Code of Values and Conduct which is discussed with all staff on the commencement of employment. This includes non-acceptance of gifts from patients and families. Eight of eight staff interviewed demonstrated understanding of professional boundaries.

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

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:

There is evidence of the on-going education and learning opportunities and the implementation of changes to practice based on evidence and the organization excels at maintaining best practice standards. The clinical governance structure and ongoing quality review process focus on clinical excellence and improvement of care for residents. Policies and procedures reference best practice Information sources. Clinical staff have access to

internet data bases and best practice policies and procedures of Oceania Care Group. The clinical manager and one of the RN's is currently completing InterRAI training for implementation of the InterRai assessment process.

The open disclosure policy is included in the resident rights policy. Staff education sessions on consumer rights include open disclosure. Review of incident records, notes in seven of seven resident records, and staff interviews indicate that the principle of open disclosure is understood and is implemented in practice.

Seven of seven residents interviewed believe effective and full communication has occurred regarding all aspects of their care. Staff wear name badges and introduce themselves to new residents before providing care. Residents interviewed know who their nurse was for that day. Interpreter services can be accessed through local community contacts. 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: It is recognised throughout Oceania Care Group that residents have the right to frank and open disclosure. The open disclosure process is defined in the open closure policy. Incident and accident records provide evidence that open disclosure is implemented. Privacy and time are made available to residents and their family members for discussion of adverse events.

All staff members wear name badges. Interpreter services are available if required. The open disclosure policy is included in the residents rights policy. Staff education sessions on consumer rights include open disclosure. Review of incident records, notes in seven of seven resident records, and staff interviews indicate that the principle of open disclosure is understood and is implemented in practice. Seven of seven residents and relatives interviewed believe effective and full communication occurs regarding all aspects of their care. 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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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:

Policy and procedures specify the organisations requirements regarding informed consent. Staff members undergo education and demonstrate understanding of the support required by residents and or their family to be actively involved in the consent process. Written consent is gained as per policy, confirmed during the clinical manager, RN and health care assistants interviews. Policy regarding advanced directives are in place. Written consent is required from all residents for retention of health information, treatment, outings and use of photographs of residents.

The admission process includes ascertaining the resident and or family's understanding of informed consent. Seven of the seven residents interviewed believe they were able to make informed decisions regarding their care. Families may assist with interpretation if required and interpreter services are available. Information regarding care is given to residents and interventions are discussed. Six of six health care assistants interviewed demonstrated understanding of meeting resident's rights in practice.

ARC requirements are met.

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

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where 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 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

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

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: Residents are made aware of their right to advocacy services and brochures for local advocacy services are available. Annual staff education is provided on advocacy rights. Staff interviews demonstrate understanding of this right and resident interviews confirm they are informed of their rights.

Seven of seven residents interviewed are aware they can have support from another person or an external advocate. The brochure regarding the independent advocacy service includes telephone contact numbers if required. Brochures are displayed in the foyer and are included in the information folder of each resident. Orientation and annual refresher in-service training includes the Code of Rights and advocacy. Staff interviewed demonstrate understanding of the Code and the resident's right to advocacy. ARC requirements are met.

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

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: Policy and resident interviews confirm visitors are welcomed. Seven of seven residents and relatives interviewed confirm they have access to visitors of their choice and the visitors are made welcome by staff. There is information of resources in the community providing an overview of services provided and how to access them. ARC requirements are met.

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

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

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: The right to provide feedback and to complain is documented in the complaints policy. Staff interviewed can describe the process for complaints management and residents are made aware of this right and the processes. A complaints register is sighted and includes actions taken in each instance.

Documented complaints policy complies with Right 10 of the Code of Rights. Code and advocacy pamphlets are displayed at main entrance. A complaint can be made verbally to any staff member who will report th to speak with the speak to the RN, clinical manager or the facility manager.

Complaints are documented and sent to the facility manager, or made as part of the resident satisfaction survey. The Code and advocacy pamphlets are displayed at main and ward receptions (sighted). Information about how to complain is included in the compendium of patient information in the bedside table in each room. Seven of seven residents interviewed are aware of their right to complain and how to do so. There are two internal complaints from the resident satisfaction surveys which are registered in the electronic incident summary system. Associated paper records are maintained by the facility manager.

The register is accessed and entries chosen at random for records review. Four complaints have been registered since the beginning of 2013. Sighted evidenced details of the complaint, dates received, actions taken and communications with the complainant. ARC requirements are met.

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

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:

The purpose, scope, direction and goals of the organisation are clearly identified in policy, the mission and vision of the organisation and through the connect values programme which was implemented throughout Oceania to recognise people who 'live and breathe Oceania values'.

The facility is managed by a suitably qualified person who has a graduate diploma in 'not for profit' management. The manager is supported by the clinical manager who is a registered nurse who has been in the service for three years.

A business plan is sighted. The facility manager states monthly status report is completed and communicated to the Oceania executive team and the board and this report is linked to the facility's business plan.

Meeting minutes and schedules are reviewed. The facility manager states staff are invited to attend the monthly quality and improvement meetings, where clinical indicators, quality data, complaints and audit results are discussed, confirmed at staff interviews.

Dunblane is certified to provide rest home, hospital and dementia level care and has contracts with the DHB to provide these services.

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

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: The clinical manager is in charge in the absence of the facility manager and is also responsible for scheduling the RN's who are on call for after hour clinical emergencies. ARC requirements are met.

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: FA
Evidence: <p>The documentation review, policies and procedures and from discussion with staff confirm there are operational management strategies and an implemented quality programme. The quality programme includes culturally appropriate care, incidents and accidents reviews, complaints and an internal audit management programme. Incidents and accidents as well as internal audits show evidence of corrective actions being addressed with resolution occurring in a timely manner.</p> <p>Policies, procedures and systems support provision of clinical care, including care planning. Policies and procedures are reviewed annually or bi-annually by the support office. The service has a document control process which includes new policies being sighted and signed off by staff confirming they have read the new or changed policies. Policies to support service delivery includes continence, challenging behaviour, pain management, personal grooming and hygiene, pressure area risk management and skin care, wound management, restraint minimisation and safe practice, clinical risk management, death and van / transportation. The service has strategies in place for management of incident and accidents which includes a comprehensive falls management programme. Review of eight staff files evidence and interviews with staff confirm they receive orientation at commencement of service with the facility.</p> <p>The service offers monthly quality improvement, staff, health and safety, diversional therapy and registered nurse meetings and weekly management meetings with the facility manager. Resident and family meetings take place bi-monthly. Resident and family concerns are discussed, corrective actions implemented and signed off at the following meeting.</p> <p>The service has an annual preventative maintenance programme which includes documentation of maintenance completed in the previous 12 months.</p>

Hazards and health and safety issues are documented. There is an emergency plan and a documented pandemic plan. Annual satisfaction surveys are completed, collated and corrective actions are implemented to address issues, and the last survey was completed in August 2013.

Quality improvements since the last audit included the addressing of issues raised in surveillance audit which are now fully implemented. ARC requirements are met.

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

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

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

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

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

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

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

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 1.2.3.9 (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: During interview the facility and clinical manager both confirm their understanding of the requirement to notify relevant authorities (DHB) in relation to essential notifications. The facility manager confirms that there has not been a need to notify the DHB of any issues since the surveillance audit. Incidents and accidents data is collected for all adverse events. The incident / accident forms are completed with evidence of corrective actions taken. The facility manager completes an analysis of incidents and accidents at monthly intervals as part of the clinical quality indicator data collected for support office. Review of five incident / accident forms confirm family are notified when incidents and accidents occur. ARC requirements are met.

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

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

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

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 1.2.7: 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: Human resources policies offer guidelines for safe and appropriate practice. Eight reviewed staff files evidence curriculum vitae, police checks,

qualifications, professional registration, training records, current appraisals, signed contracts, job descriptions and evidence of induction and orientation. Relevant checks are completed to validate individual qualifications and experience and the service completes reference checks with previous employers. The facility manager maintains a record of annual practicing certificates which includes registered nurses, enrolled nurses, general practitioners, pharmacists, podiatrist and dietitian.

Orientation of new staff includes a buddy system for a number of shifts working alongside an experienced caregiver, confirmed during interview with health care assistants and the facility manager. The facility manager states that all staff members working in the dementia unit have completed the dementia care certificate, also confirmed during the review of staff records.

The service has a system to identify, plan, facilitate and record on-going education and training for all staff, sighted the education and training programme. Seven residents (three the rest home and four in the hospital) and seven family interviewed (three in the dementia unit, two in the hospital and two in the rest home) state that staff are skilled, competent and respect the privacy of their loved ones. 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 interim staffing policy determines staffing levels and skill mixes for safe and appropriate service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Staffing includes the following: Dementia unit: Two days a week there is a registered nurse on during the morning shift. Two caregivers in the morning (one short shift. Afternoons are covered by a staff member on a full shift and one on a short shift. There is one staff member on at night.

Hospital: One registered nurse for a full shift, an enrolled nurse for a short shift, three health care assistants for a full shift and two health care assistants (HCA) for a short shift. In addition to that, the service has another short shift staff member on a Tuesday and Thursday. In the afternoon there is a registered nurse and three full shift HCA's and two short shift HCA's on duty. There is a registered nurse and two HCA's on duty during the night.

Rest home: Two full shift HCA's for the mornings. In the afternoons there are two full shift HCA's on duty and in the evening there is one full shift staff member on duty.

The facility manager is on site five days a week as is the clinical manager (registered nurse). There are a total of 64 staff employed in the service excluding the facility manager, seven registered nurses and two enrolled nurses.

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 their records which includes information gathering at admission, with the involvement of the residents and their family. There is sufficient detail in resident files to identify residents' on-going care history and activities. There are policies and procedures in place to guide privacy and confidentiality. Staff members can describe the procedures for maintaining confidentiality of resident records.

There are systematic and reliable resident information and records management systems in place. Resident records are maintained in accord with good practice and protected from unauthorised access. An electronic data base of all patients is maintained by the administrator. The resident details are entered into the electronic information and demographic and administration details are entered on the day of the admission.

Documented policies and guidelines were sighted that identified the details required to be recorded in both the electronic administration record and the clinical hard copy record. Clinical records include admission, consent, health questionnaire, medications, nursing care, progress notes and discharge information.

Clinical records audits are completed to ensure that resident information is documented to the required standard. There is a secure process for providing access to resident records. The service store archived records in the attic. The resident files are packaged into archiving boxes, identified and then stored. Education relating to privacy and confidentiality is provided to all staff two yearly.

All electronic systems are backed up daily through support office. All records pertaining to the residents are held in the one clinical record, are updated by staff as care is provided. Staff entries in all resident records sighted during the audit were legible, written in ink, dated, signed and designated by the service provider. A list of staff sample signatures was sighted. Medication charts are in a separate folder and kept in the medicines room. 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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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: <p>Resident's entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. Pre-admission packs are provided for families and residents prior to admission. Admission agreements are sighted for seven out of seven resident's file reviewed and is kept in the reception office. 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. Evidence of the completed admission documents is also sighted. The RNs receive hand overs from the hospital and utilise these information's in creating the appropriate plan of care for the resident.</p> <p>ARC requirements are met.</p>

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

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 is clearly stated. The CM assesses the suitability of the resident through an enquiry form which is kept in the CMs office. When not suitable, the family and/or resident are referred to other facilities depending on their level of need.

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: FA

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). All RNs and CM have current practising certificates as sighted in their respective files. Daily interventions and support with activities of daily living are implemented with the help of trained healthcare assistants (HCAs) and two qualified diversional therapists (DT).

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 including RN assessment, cognitive, mobility, Tinetti risk, Abbey pain, Waterlow, oral, dietary, nutrition, hydration, continence, cultural and recreation. Medical assessment is completed 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 also developed as and when required for acute problems. All PCCPs are reviewed every three months and updated when required as sighted. GP reviews are also conducted every three months. The two GPs interviewed confirm that the RNs and CM always contact the practice regarding any medical issues and orders are implemented in a timely manner. The two GPs also reported that the clinical team is very competent in performing their roles.

Continuity of care is maintained as sighted in all seven out of seven resident's file sampled. The GP's entries and visits as well as from allied health providers are sighted. A daily hand over between staff also ensures continuity of care. During the first day of the audit, an afternoon hand over is observed and confirms accurate and comprehensive information's are communicated by the RN. 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. The resident's file is divided into sections i.e. profile, resident details, observations, PCCP and risk assessments.

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

Tracer Methodology one – dementia level of care:

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

Tracer Methodology two- hospital level of care:

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

Tracer Methodology three – rest home level of care:

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

ARC requirements are met.

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

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

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: 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 1.3.3.4 (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 complete a number of risk assessment tools on admission i.e. RN assessment, cognitive, cultural, 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. The CM added that the families are involved in the assessment process. The outcomes of the assessments are utilised by the RNs, CM or DT in creating an initial plan, PCCP and recreational plan. 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>The PCCPs of seven out of seven resident's files reviewed are resident focused, integrated, and promote continuity of service delivery. An initial plan of care is developed on admission while the plans PCCPs 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 resident's profile, details, observations, PCCP, monitoring and risk assessments. 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, achievable and specified time is clearly stated.</p> <p>ARC requirements are met.</p>

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

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: PA Low
Evidence: <p>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 but the interventions sighted in eight out of ten PCCPs are inadequate to address the desired goals. This is an area for improvement in 1.3.6.1. For example mobility- other factors to maintain or improve a resident's mobility is not clearly defined. Other considerations like pain, appropriate footwear and walking aids are not included in the interventions when addressing the domain in mobility. The GP when interviewed stated that clinical interventions are effective and appropriate to address the desired outcomes.</p> <p>Interventions from allied health providers are also included in the PCCP i.e. speech language therapist and physiotherapist.</p> <p>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 that will meet optimal levels of functioning of the resident. Ten out of ten sighted PCCPs are signed by either the resident or by their families/next of kin.</p> <p>ARC requirements are not met.</p>

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: PA Low
Evidence: The provision of services and interventions are consistent with, and contribute to, meeting the resident's assessed needs, and desired outcomes. There are documented interventions in ten out of ten PCCPs sighted but the interventions are insufficiently detailed to address the resident's needs.
Finding: The interventions in eight out of ten PCCPs sighted are not adequate to support the goals/desired outcomes to address the needs of the residents.
Corrective Action: Ensure that the planned interventions are sufficiently detailed to address the needs of the residents.
Timeframe (days): 60 (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: FA
Evidence: The activities programme provided for the residents reflect that independence is encouraged and choices are offered. The diversional therapists (DT) coordinate the programme. One of the DTs daily updates the activities boards including the menu of the day. One of the DTs focuses in the dementia unit and creates 24-hour dementia-specific activities as sighted. The activities resource materials in the dementia unit are accessible for the staff to utilise. During the day of the audit, the DT in the dementia unit took the residents for an outing and the residents returned very happy. Activities include physical, mental, spiritual and social aspects to improve/maintain well-being of the residents. The DTs complete the recreation assessment for each resident, which identifies personal interests and hobbies to ensure participation in the activities provided in the facility. After completing the assessment, the DTs provide the RNs with the assessments which will be transferred in the PCCPs. A monthly review is sighted in the progress notes of the seven out of seven resident's file sampled as well as three monthly reviews through a multidisciplinary review (MDR) meeting. Residents interviewed verbalise that they enjoy staying in the facility due to the variety of activities provided. Preferences are considered and interests are maintained. The DT reported that outings as well as entertainers from the community are much enjoyed by the residents. ARC requirements are 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: 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 1.3.8: 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: <p>Ten out of ten sampled PCCPs 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 for acute problems like infections are created as required. Additional reviews include the three monthly medication reviews by the GP.</p> <p>ARC requirements are met.</p>

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: The CM 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 their local hospital. The GP confirms involvement in the referral process.

A formal referral process exists which involves identification of risk and involvement of family when required. Evidences of recent external referrals to the speech language therapist and podiatrist are included in the sample. Referrals are kept at the back of the resident's files as sighted.

ARC requirements are met.

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

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:

Planned exits, discharges or transfers are coordinated 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.

In the event of a discharge or transfer to another provider, the resident's records are copied including GP visits, medication charts, current PCCPs, upcoming hospital appointments and other medical alerts.

ARC requirements are met.

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: <p>A medicines management policies and procedures are in place but are not all implemented in practice including safe and appropriate prescribing, dispensing and administration of medicines. All sampled medication charts are reviewed three monthly by the GP. Some medication charts are “ditto” signed blocked signed and not dated by the GPs. Several medicines are crushed without appropriate documentations or guidance from the pharmacy or the GP.</p> <p>A blister pack medication system is implemented. All medicines are prescribed by the GPs using pharmacy generated medication charts. Medication reconciliation policies and procedure is implemented. A medication fridge is monitored regularly. Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. Sharps bins are also sighted. Unwanted or expired medications are collected by the pharmacy regularly.</p> <p>There is no resident who self-administers own medication. Self-administration of medicine policies and procedures are in place and sighted. The CM and the RN are able to discuss the self-administration procedure in details.</p> <p>ARC requirement D1.1g is not met.</p>

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:

A medicines management policies and procedures are in place but are not all implemented in practice including safe and appropriate prescribing, dispensing and administration of medicines. All 14 out of 14 medication charts are reviewed by the GPs every three months. Seven medicines are crushed without appropriate documentations or guidance from either the pharmacy or from the GP. The GP "ditto" signs five out of 14 medication charts. One of 14 medication chart is blocked signed by the GP. Two of 14 medication charts do not have the year it is prescribed. The CM contacted the GP during the first day of audit to ensure that guidelines will be documented in the resident's files. Evidence of documented guidelines is sighted in the resident's progress notes. During the day of the audit, the CM was able to obtain guidelines from the pharmacy and will be creating new medication charts with guidelines on what medications to be crushed in the new medication chart.

A blister pack medication system is implemented. All medicines are prescribed by the GPs using pharmacy generated medication charts. The facility has approximately 30 prescribing GPs from nearby medical centres. All medication charts include current photos and allergies. Three monthly reviews are evident in 14 out of 14 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, non-packed medications and injectable. Both packed and non-packed medications are safely stored in the three medication rooms. A medication fridge is in the hospital unit which is monitored regularly as sighted. There is a medication cupboard 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. A sharps bin is sighted in each medication room.

All unwanted or expired medications are collected by the pharmacy staff regularly. A pharmacy returns policy and procedure is in place and implemented. A medication disposal log is sighted. The expired medications are kept in a plastic container above the cupboard to avoid accidental usage.

There is currently no resident self-administering own medication. Self-administration policies and procedures are in place and sighted. The CM and the RN are able to discuss the self-administration procedure in details.

All staff who administer medications are all competent as sighted in the register.

Finding:

The EN/RN report that seven medications are crushed without adequate documentation or guidelines from the GP or from the pharmacist.

There are 5 out of 14 medication charts block signed, ditto signed, not dated or no year written on it.

Corrective Action:

Ensure that crushed medications are supported by adequate documentation and guidelines to comply with the current medication legislation.

Ensure that all medications are individually dated and signed by the GP.

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 1.3.12.6 (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 menu is reviewed by the dietician last September 2013 while the winter menu is due for review on April 2014. 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 are catered for. The facility also provides modified diets e.g. puree diets to meet the dietary requirements of the residents. The kitchen provides milkshakes for residents who are losing weight or for the residents in the dementia unit. 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 reminders about modified diets as well as preferences of the residents.

The cook is interviewed and manifests good knowledge and passionate 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. There is no food that touches the floor. 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 freezer temperatures are monitored three times a day and evidence is sighted and is within the acceptable temperature ranges.

The cook and the kitchen assistant have current food handling certificates as sighted.

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 when plated show good presentation to entice appetite and sufficient 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.

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.1: 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:

The Oceania health care waste policy includes medical waste, soiled disposable waste, wet linen, sharps, body fluids / waste, equipment cleaning and who approves policy.

The infection control policy includes; standard precautions policy, hand hygiene policy, use of gloves policy, respiratory etiquette, isolation precautions, outbreak management, outbreak register, notifiable diseases, single use items, safe management of sharps, accidental exposure to blood / body fluids, blood and body fluid accident notification, soiled linen, spills of blood / body fluids, cleaning the environment, health care waste, renovations and construction, staff with infections guidelines, guidelines for immunisation of staff and residents, flu vaccination consents, staff vaccination records, anti-microbial usage, infection control surveillance and anti-microbial resistance organisms, sighted and confirmed during interviews with the clinical manager and facility manager. The service has personal protective equipment (PPE) available and displayed in the sluice rooms and in the chemical storage room (upstairs), sighted and confirmed at the business and care manager interview. The cleaners rooms and chemical storage room are locked confirmed during interview with the clinical manager and the facility manager.

Infectious and hazardous substances are being collected by a contractor who specifically provides services for removing hazardous substances. Staff collect infectious waste into yellow bags, double bagged and then put into the contractors' skip. The service has gloves, aprons, masks, protective shoe covers, goggles and visors available for staff to ensure risks are alleviated during handling of infectious or hazardous waste. 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:

The facility warrant of fitness (WOF) expires on 1 December 2014, sighted.
The service has a full automatic sprinkler system, emergency warning system for fire in the form of smoke detectors and mimic boards, automatic doors that are also smoke separation doors controlled doors, emergency lighting, an automatic back-flow prevention for water supply, air conditioning in the kitchen, emergency power signs and systems and fire exits. The service completed a fire evacuation training day for current staff members in November 2013.

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of rest home and hospital and dementia level care. The residents are provided with a safe and accessible external environment with raised plant boxes, ramps at exit doors which are flush and easy to use. The service have 16 doors exiting the facility, verified, and confirmed during the facility manager and the maintenance person interviews.

The physical environment minimises risk of harm and promotes safe mobility in that corridors are wide and allows for safe mobilisation and there are rails attached to the walls to ensure residents have opportunity to hold on when the need presents itself. Residents have access to five courtyards where residents are provided with seating and appropriate cover, verified and confirm at resident, the maintenance person and the facility manager interviews. 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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

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

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: The service has two bathrooms, three showers and nine toilets for 27 beds in the rest home. In the hospital there are 15 ensembles, for the rest of the beds(19) there are two bathrooms, three showers and ten toilets. In the dementia unit there is one bathroom, two showers and five toilets for up to 14 beds, this was confirmed at the facility manager interview and verified during the tour of the facility. Resident interviews confirm they do not have to queue for toilets and believe that the number of toilet and shower facilities provide in their needs. 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Space is provided to allow residents to safely move around their personal space and those residents that have mobility aids to safely use their mobility aids within their personal space, verified the space in bedrooms and confirmed with the facility manager and residents during interview. The service provides 34 single rooms in the hospital, 27 single bedrooms and 14 single bedrooms in the dementia unit. Residents do not share bedrooms, confirmed at resident and the facility manager interviews. 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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 hospital offers a sunroom and two dining room and lounge (combined) for residents to use, the rest home provides communal areas in the form of two dining room / lounges the dementia unit has a dining room and lounge, verified during the tour of the facility and confirmed during the facility manager and resident interviews.

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

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:

The methods, frequency and materials used for cleaning and laundry processes are in place to ensure effective management of the services. The service has two cleaners five days a week and over weekends there is one cleaner on duty. Cleaning trolleys are not left unattended. Chemicals are being stored, verified, and each trolley has a copy of the duties and the required tasks, sighted and confirmed during the facility manager and the clinical manager interviews.

The two cleaner rooms and the chemical storage room have material safety data sheets (MSDS) with guidelines for interventions when needed, sighted.

The facility has a designated chemical storage room for the safe and hygienic storage of cleaning, laundry equipment and chemical products, verified. ARC requirements are met.

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

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

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:

Employees receive appropriate information, training and equipment to respond and identify emergency and security situations, sighted records confirming the trial evacuation training that occurred in November 2013 and sighted the training programme for new employees.

Security of the facility includes a security guard sweep once per night completing a random check that the facility is locked up. The external doors are locked manually and checked after dark and family confirm they still have access to the facility through ringing the front door bell.

The service has a call bell system and residents confirm the call bells are answered in a timely manner. The maintenance person completes hot water checks throughout the month maintaining the temperatures under 45 degrees Celsius. The maintenance person also does a second check on fridge temperatures to ensure compliance. 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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:

All areas are ventilated by opening large windows and sliding doors throughout the facility. The facility is heated by hot water heating throughout the facility confirmed at the facility manager interview. Showers have vents and extraction fans. All bedrooms, communal areas and corridors have large external windows allowing natural light into the building, verified and confirmed at the facility manager interview.
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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:

The facility demonstrates that the use of restraint is actively minimised. Restraints used in the facility are lap belts, bedrails and bed pole. There are currently six residents on bedrails, three residents use bedrail as an enabler, one resident uses a bed pole as an enabler and one resident on a lap belt. The file reviewed on four residents who uses an enabler is voluntary and the least restrictive option for the residents. Restraint minimisation policies and procedures are implemented in practice. All six residents on restraint have a risk management plan in place and sighted in the PCCP. 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.

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 are documented in the restraint assessments. Three monthly restraint reviews are evident. Definitions are congruent with requirements of the HDSS standards and staffs interviewed are aware of the difference between a restraint and an enabler. Restraint competencies are all current. There are guidelines in place in managing challenging behaviour. Staffs receive adequate training as per education planner. Restraint and challenging behaviour competencies are conducted on February 2014.

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

The relevant ARC requirement is met.

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 to 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 on restraint and challenging behaviour are evident in February 2014. Staff are made aware of the residents on restraints during monthly staff meetings.

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

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:

The CM is the restraint coordinator and ensures that rigorous assessment of the resident is undertaken in relation to the use of restraint. The restraint coordinator job description is signed and is kept in the staff file. The restraint coordinator completes a restraint assessment form prior commencing a restraint. Risk management plan is created and implemented to ensure the safety of the resident and to guide the HCAs and RNs in managing resident on restraint. Desired outcomes are defined in the risk management plan.

The relevant ARC requirements are met.

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

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:

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 a restraint. Authorisations are sighted and signed by the GP, family/resident and the restraint coordinator. The restraint monitoring forms are completed 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.

The sighted restraint register is current with the dates commencing and ending the restraint is noted.

The relevant ARC requirements are met.

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

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

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

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:

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 involved in the evaluation of the restraints' effectiveness and continuity. Documentations are also sighted in the progress notes of the residents on restraint. Restraint minimisation and safe practice is reviewed on March 2014.

The relevant ARC requirement is met.

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

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: <p>The facility demonstrates the monitoring and quality review of their use of restraint. Quality audit schedule is sighted and restraint minimisation is reviewed on March 2014. 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.</p> <p>The relevant ARC requirements are met.</p>

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

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: The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The infection control co-ordinator is new to the role and had attended a two-day infection control training in the DHB. The infection control committee has representatives from the kitchen, cleaning services, laundry, HCA and the CM. Monthly meeting is evidence. The infection control co-ordinator also reports that hand-washing audit is in planning stage.

There is a clearly defined infection control programme that is last reviewed on February 2013. Infection control is part of the monthly staff meeting agenda. When a resident is suspected of having urinary tract infection (UTI), the RN performs an assessment, obtains mid-stream urine sample (MSU), performs a dipstick and sends urine to the laboratory for sensitivity. The GP prescribes antibiotic as per sensitivity. The RN creates a short term care plan and reviews the effectiveness of the prescribed antibiotics when the treatment is completed. The CM collates all the surveillance data for benchmarking. Evidences that infections are discussed during staff meetings and appropriate interventions and plans are also sighted.

There are sanitary gels available all throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. The infection control co-ordinator also mentions that placing more sanitary gels in other areas is included in the infection control committee plan for the year. Staffs interviewed are able to explain when not to come to work.

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

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:

There are adequate human, physical, and information resources to implement infection control programme and meet the needs of the organisation. Hand washing signs are sighted around the facility to remind staff and residents the importance of proper hand washing. The infection control co-ordinator plans to conduct hand washing audit on April 2014. The facility maintains regular in-service trainings for Infection Control including standard precautions, personal protective equipment's, cleaning, infectious diseases and hand washing.

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

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: <p>Documented policies and procedures for the prevention and control of infection reflect accepted good practice and relevant legislative requirements and are readily available and are implemented in the facility. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. The policies and procedures sighted comply with relevant legislation and current accepted good practice. The service evidences implementation of the policies and procedures.</p> <p>The relevant requirements are met.</p>

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:

The organisation provides relevant education on infection control to all service providers, support staff, and residents. The infection control education is provided by either by the CM or outside resource speakers. The infection control co-ordinator is new to the role and plans to implement other infection control programmes of the organisation including hand washing and standard precautions. Residents interviewed are also aware of the importance of hand washing and mentioned when hand washing is required.

The relevant ARC requirement is 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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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: Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. The infection control committee consisting of the CM, 1 kitchen, 1 cleaning, 1 laundry, 1 HCA, and the infection control co-ordinator which is adequate for the size and complexity of the organisation. Infection control process is in place and documented. Monthly infection log and antibiotics use is sighted. The organisation has an internal benchmarking system. Infections are investigated and appropriate plan of actions are sighted in the minutes of the meeting. The surveillance result is discussed in the staff meeting.

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.)*