

Oceania Care Company Limited - The Oaks Lifestyle Care & Village

Current Status: 27 March 2014

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

General overview

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

The Oaks Lifestyle Care & Village is certified for 102 beds. On the day of this audit there were 80 residents who receive rest home or hospital care (36 are rest home level care and 44 hospital level care residents).

The two areas identified as requiring improvement at the last certification audit around documentation of infections in residents' care plans and General Practitioners clinical review exceptions are fully attained. One area identified requiring improvement at the last certification audit around call bells remains.

There are new areas identified at this surveillance audit that require improvement around the complaints process, staff orientation and staff rosters.

Audit Summary as at 27 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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 27 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.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 27 March 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 27 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.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 27 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Restraint Minimisation and Safe Practice as at 27 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 27 March 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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 - The Oaks Lifestyle Care & Village
Designated Auditing Agency:	Health Audit (NZ) Limited
Types of audit:	Surveillance Audit
Premises audited:	The Oaks 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: 27 March 2014 End date: 28 March 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	80

Audit Team

Lead Auditor	XXXXX	Hours on site	16	Hours off site	4
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	XXXXX			Hours	2

Sample Totals

Total audit hours on site	32	Total audit hours off site	10	Total audit hours	42
Number of residents interviewed	6	Number of staff interviewed	9	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	9	Total number of managers (headcount)	3
Number of medication records reviewed	12	Total number of staff (headcount)	75	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Friday, 4 April 2014

Executive Summary of Audit

General Overview

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

The Oaks Lifestyle Care & Village is certified for 102 beds. On the day of this audit there were 80 residents who receive rest home or hospital care (36 are rest home level care and 44 hospital level care residents). There are 11 apartments and 25 studio units that can be used as independent living, rest home or hospital care. The 102 beds are divided into two buildings, which are divided by porticos.

The two areas identified as requiring improvement at the last certification audit around documentation of infections in residents' care plans and General Practitioners clinical review exceptions are fully attained. One area identified requiring improvement at the last certification audit around call bells remains.

There are areas identified at this surveillance audit that require improvement around the complaints process, staff orientation and staff rosters.

Outcome 1.1: Consumer Rights

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

Outcome 1.2: Organisational Management

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

The Oaks is managed by a business and care manager, who is supported by a clinical manager, who is a registered nurse (RN) and a clinical and quality manager from Oceania (RN).

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

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

There is a documented rationale for determining staff levels and staff skill mixes. There is a registered nurse on duty 24 hours a day with on-call support from the business and care manager and the clinical manager. There is an area requiring improvement around adhering to the rostering policy.

Outcome 1.3: Continuum of Service Delivery

The residents receive timely and competent services meeting their needs. Residents confirm involvement throughout service delivery and staff are suitably qualified to render the services. Nursing assessments are comprehensive. The service completes risk assessments. Progress notes and the incident and accident records reflect family and whanau contact where appropriate. Services are coordinated in a manner that promotes continuity of service delivery and promotes a team approach.

Provision of services and interventions are consistent with and contribute to meeting the resident's assessed needs and desired outcomes. Resident files include six-monthly reviews of the care plans. Sampled files evidenced progress notes reflecting interventions and implementation of services. Care plans are personalised, specific and appropriate with goals and desired outcomes recorded.

Activities are appropriate to the service setting, needs and age and culture of the residents. The services policies and protocols describe processes to manage safe and appropriate prescribing, administration, review, storage, disposal and medicines reconciliation which comply with legislation. Medicines received from the pharmacy are checked by the pharmacy and checked by the registered nurse. The lunch time medicines round was observed. All staff members who administer medicines have medicines management competencies completed and signed off for the last twelve months. The service has two residents who self-administer medicines in a safe and appropriate manner. The previous required improvement relating to general practitioner exceptions for residents who are clinically stable have been adequately addressed.

Resident's individual food and nutritional needs are identified through assessment. The nutritional needs for the residents are identified on admission to the service. Resident and the relative interviews confirm that they enjoy the food. Residents with additional or modified nutritional needs and requirements or special diets have their needs met.

Outcome 1.4: Safe and Appropriate Environment

There is a current building warrant of fitness.

Outcome 2: Restraint Minimisation and Safe Practice

The service demonstrates they actively work towards minimising the use of restraint. The use of enablers is voluntary and the least restrictive option meeting the needs of the residents with the intention of promoting and maintaining the resident's independence and safety. The service maintains a restraint and enabler register.

Outcome 3: Infection Prevention and Control

The infection prevention and control coordinator reports on infection control issues on a monthly basis at the staff meeting and submits a written report to the business and care manager. The surveillance is appropriate for the size and complexity of the service.
The service participates in benchmarking through Oceania Care Group by submitting monthly infection control reports.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	3	1	0	0
Criteria	0	35	0	1	3	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	33
Criteria	0	0	0	0	0	0	0	62

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S .2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S .2008	Criterion 1.1.13.1	The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Moderate	One verbal complaint dated 25 February 2014 is recorded on the 2014 complaint register and evidences the policy guidelines to record all complaints on the complaint form has not been followed. This verbal complaint was reported to the business and care manager, who recorded the complaint (list of 12 specific complaints relating to care services, loss of clothing, housekeeping, communication with family, food service, activities) on a typed note without a	Provide evidence the complaint processes are implemented to comply with Right 10 of the Code.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				signature or designation on this record.		
HDS(C)S .2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S .2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Review of the business and care manager's induction and orientation file evidences the orientation checklists have not been completed within the required timeframe or sent to human resources manager at support office. One of the nine staff files evidences an orientation programme is not completed.	Provide evidence staff induction / orientation is completed within required timeframes.	180
HDS(C)S .2008	Standard 1.2.8: Service Provider Availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low			
HDS(C)S .2008	Criterion 1.2.8.1	There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	Roster sighted evidences one RN was rostered to work on an afternoon shift had also worked a night shift on the same day to cover for annual leave. The total of 16 hours worked in one shift (pm and night shift combined) may pose the risk of potential safety issues due to staff tiredness and potential risk of poor decision making.	Provide evidence of adhering to Oceania rostering methodology policy.	30
HDS(C)S .2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate			
HDS(C)S .2008	Criterion 1.4.7.5	An appropriate 'call system' is available to summon assistance when required.	PA Moderate	The auditor tested number of call bells in the hospital wing of the facility and one call bell was not working. The maintenance person was asked to test all call bells at the facility on audit day and it was found that	Provide evidence all call bells function to summon assistance.	1

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				six call bells were not working. Two of the six rooms with non-functioning call bells were not occupied. Call bells in two of the four occupied rooms were able to be fixed by the maintenance person on day of audit. The contractor was called out to fix the other two remaining non-functioning call bells in the two remaining occupied rooms, which were still not functioning when the audit was completed.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

<p>There are policies and procedures in place to support the open disclosure practice in the facility. Staff education on open disclosure was last provided in September 2013. Incident/accident forms, residents' progress notes and family communication forms evidence family are informed of adverse events or when resident's condition alters. Residents (three rest home and three hospital) and family members (three hospital) interviewed confirm that staff and management communicate well with them. Service information is available and appropriate to the communication needs and capabilities of the residents, families and referring agencies. Full details of resident's rights to receive or not receive additional services and charges for additional services are set out in the Admission Agreement. The business and care manager advises there are no residents requiring interpreter services at time of audit.</p>

Related ARC requirement 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 1.1.13: 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: PA Low

Evidence:

The complaints policy, procedures and flow chart are congruent with Right 10 of the Code of Rights. There is a complaints register which is current and monitored by the business and care manager. Complaints registers for 2013 and 2014 were reviewed. Complaints procedure audit was last conducted in November 2013 with corrective action identified and actioned. Staff education on complaints processes was last conducted in November 2013 and staff interviews confirm they are aware of the complaints process.

The complaints process documentation is included in the facility welcome and information pack and compliment, complaint or suggestion form is located at entrance to the facility.

Six of six residents (three rest home and three hospital) and three of three hospital family members interviewed are aware of the complaints processes. Health and Disability Commissioner (HDC) brochures on Code of Rights are displayed at the facility. The Nationwide Advocacy Service and the HDC contact details are available at the facility.

The business and care manager, the clinical manager and the clinical and quality manager state they are not aware of any complaints since the last certification audit, referred to the Health and Disability Commission, police, coroner, accident corporation or Ministry of Health.

ARC requirements are not fully met.

There is an area requiring improvement around the implementation of the complaints processes to comply with policy and the Code.

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: PA Moderate

Evidence:

The complaints policy and procedures are congruent with Right 10 of the Code of Rights.
The complaints register is current and monitored by the business and care manager. Complaints registers for 2013 and 2014 is reviewed.

Finding:

One verbal complaint dated 25 February 2014 is recorded on the 2014 complaint register and evidences the policy guidelines to record all complaints on the complaint form has not been followed. This verbal complaint was reported to the business and care manager, who recorded the complaint (list of 12 specific complaints relating to care services, loss of clothing, housekeeping, communication with family, food service, activities) on a typed note without a signature or designation on this record. There is no recorded evidence of this complaint being acknowledged in writing within five working days of receipt and no recorded evidence of the complainant being informed of the availability of an independent advocate. The complaint register is dated 6 March 2014, seven days post the complaint being made, as the date when the complaint was verbally acknowledged. Interview with the business and care manager confirms the complaint form was not completed and written acknowledgement did not occur. The business and care manager was away from the facility at that time, for orientation at Oceania support office and states upon returning back to the facility, the resident's family made arrangements for the resident to be transferred to another residential care facility. A letter is located on file (not dated) evidencing the resident and family wishes for the resident to move to another residential care facility on 6 March 2014 and that approval was obtained from Aged Persons Welfare at Christchurch District Health Board (CDHB) for this transfer to occur. The business and care manager states they were made aware of this letter upon returning back to facility from their orientation. Corrective actions are typed on a separate form, however they have not been signed off or communicated to the complainant. The business and care manager states a phone conversation occurred with the complainant and a meeting was arranged, however this did not occur as the residents was transferred to another residential care facility.

Corrective Action:

Provide evidence the complaint processes are implemented to comply with Right 10 of the Code.

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Oceania Care Company Limited has systems in place which record the scope, direction and goals of the organisation and the facility. Monthly reports to the governing body are provided by the business and care manager and the clinical manager via the Oceania intranet and include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators, sighted. Oceania values, mission statement and philosophy are displayed at entrance to the facility.</p> <p>The Oaks business plan was sighted and the business and care manager states it is in the Oceania support office for approval.</p> <p>The business and care manager has been in this position for two months and is supported in their role by a clinical manager / registered nurse (RN) and Oceania clinical and quality manager/RN. The business and care manager has completed post graduate diploma of business studies and their past experience includes senior leadership roles within the banking sector. Sighted Oceania induction/orientation manual for the business and care manager (refer to criterion 1.2.7.4).</p> <p>Interview with the clinical and quality manager confirms the previous facility manager terminated their employment in August 2013. A temporary facility</p>

manager was appointed for the month of September 2013 and the clinical and quality manager commenced employment in the role of the facility manager for this facility in October 2013 until January 2014.

The clinical manager /registered nurse (RN) is employed in a full time position to work with the business and care manager and has responsibility for the management of compliance with all clinical matters. The clinical manager has worked in another Oceania facility in the role of clinical leader from May 2013 to January 2014, when they commenced employment at The Oaks. The clinical manager states they hold a post graduate certificate in speciality nursing (cardiology) and have worked in this field as a clinical nurse specialist prior to commencing employment in aged care.

All staff requiring practising certificates have current practising certificates.

The Oaks Senior Care Centre has contracts with Christchurch District Health Board (CDHB) for aged related residential care for hospital services (medical and geriatric) and rest home services; aged related residential respite care and support Care End-of-Life Support and SupportCare Severe Medical illness Support, Long Term Support-Chronic Health Conditions and Residential –Non aged Rest home and hospital.

Related ARC requirements met.

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

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

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

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:

There are quality and risk management systems in place including a clinical risk management plan and quality improvement policy, sighted. There is evidence the quality improvement data is collected, collated, evaluated, and analysed to identify trends and if corrective actions are required this is developed and implemented.

Meetings are conducted as per the education and meeting schedule, sighted 2013 and 2014 schedules. The health and safety / infection control committee meetings occur monthly; the quality improvement and staff meetings and the registered nurse and enrolled nurse and restraint meetings also occur monthly. Residents' meetings occur bi-monthly on the schedule for 2014, sighted minutes of meetings for June, August, September and November 2013.

An internal audit schedule and completed audits for 2013 and 2014 were reviewed. Quality and risk management data and quality improvement data is reported and discussed at the facility's meetings. Meeting minutes reviewed evidence this.

Policies and procedures reflect current accepted good practice and reference legislative requirements. Staff interviews (five health care assistants, four registered nurses) confirm staff are informed of new / updated policies and staff signing sheet demonstrate staff have read and understand the new/reviewed policies. Document control policy and procedure for new or reviewed documents is recorded and implemented.

Health and safety manual documents health and safety management systems including health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements emergency plan. Hazard registers are sighted. Minutes of health and safety meetings are sighted (February 2014). Oceania holds Workplace Safety Management Practices at tertiary level for ACC workplace safety and this expires on 31st March 2015.

Residents and family satisfaction survey was last conducted in July 2013 and there is evidence in the September 2013 residents' meetings and quality improvement and staff meeting of discussion in respect of the survey results and evidence of actions taken in response to the survey results.

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: <p>There is an adverse event reporting system in place. All accident/incidents are recorded and reported on the Oceania intranet as part of the monthly clinical indicators that record incidents relating to absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse. Communication with families following adverse events, or any change in resident's condition is evidenced in the residents' files reviewed. Staff interviews confirm awareness of the adverse event reporting process. Sighted two sentinel event documentation (one in January 2014 and one in March 2014). Review of documentation evidences all required documentation is completed and investigations and corrective actions recorded and implemented and notification to Oceania support office conducted. Staff are made aware of their essential notification responsibilities through their job descriptions, Oceania policies and procedures and professional codes of conduct. Accident /incident audit was last conducted in September 2013 with corrective action required and this has been documented and implemented. Related ARC requirements are met.</p>

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

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

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

Evidence:

There are policies and procedures in relation to human resource management.
There is a planned and documented staff in-service education plan and staff attendance records are maintained, sighted for 2013 and 2014 in-service education plan and staff attendance records. Oceania's training programme caters for all of the roles within the organisation and is intertwined with the Oceania Career Pathway Programme (CPP). There is an Oceania training planner that maps out courses and dates that staff can book into and is used with clinical in-service sessions provided at the facility.
Annual practising certificates are current for all staff who require them to practice.

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff interviews confirm orientation / induction is provided for new staff.
Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

Nine of nine staff files evidence human resources systems are adhered to except orientation documentation and this requires an improvement.
ARC requirements are not fully 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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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: PA Low
Evidence: Policies and procedures record orientation requirements. Staff interviews confirm orientation of all new staff occurs. Nine of nine staff files reviewed (one cook, two RNs, one enrolled nurse (EN), one clinical manager, and four health care assistants). Review of the business and care managers orientation programme was also conducted.
Finding: Review of the business and care manager's induction and orientation file evidences the orientation checklists have not been completed within the required timeframe or sent to human resources manager at support office. One of the nine staff files evidences an orientation programme is not completed.
Corrective Action: Provide evidence staff induction / orientation is completed within required timeframes.
Timeframe (days): 180 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: PA Low
Evidence: <p>There are documented staffing rationale policies for determining staffing levels and skill mixes. There is one clinical manager /RN employed, 13 registered nurses (RNs) and two enrolled nurses (ENs). Staff who require registration to practice have current annual practising certificates issued by the relevant responsible authorities. Clinical staff (four RNs and five health care assistants) interviews confirm staff are able to get through their work. Residents interviewed state the care they receive is appropriate to their needs. Rosters evidence business and care manager and the clinical manager (RN) work Monday to Friday and on call after hours. There is a registered nurse cover 24/7. Sighted staff rosters and there is evidence of use of a RN on afternoon and night shift within the 24 hour period and this requires an improvement. ARC requirements are not fully met.</p>

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: PA Moderate

Evidence:

There are documented staffing rationale policies for determining staffing levels and skill mixes. Sighted draft copy of the rostering methodology policy that states employees may be requested to work extra shifts at short notice. The policy states ;"Shift" shall mean a set of defined rostered hours of work that may be either a continuous period of work for up to 12 hours duration or two split periods of work with a span of 14 hours and shifts will be no longer than 12 hours in duration.

Finding:

Roster sighted evidences one RN was rostered to work on an afternoon shift had also worked a night shift on the same day to cover for annual leave. The total of 16 hours worked in one shift (pm and night shift combined) may pose the risk of potential safety issues due to staff tiredness and potential risk of poor decision making.

Corrective Action:

Provide evidence of adhering to Oceania rostering methodology policy.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Each stage of service provision (the resident assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and experienced staff members who are competent to perform the function. Service provision is provided within the time frames that safely meet the needs of the residents. The service is coordinated in a manner that promotes continuity and promotes a team approach during service delivery.

Tracer methodology in the Rest Home:

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

Tracer methodology in the Hospital:

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

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

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

Attainment and Risk: FA

Evidence:

Six of the six resident files sampled have initial nursing assessments, a variety of risk assessments, person centred care plans (PCCP) with evidence of six-monthly reviews of the care plans completed. All the sampled files evidenced progress notes reflecting interventions and implementation of services. Reviews take place in a timely and appropriate manner (confirmed at relative, resident and the clinical manager interviews). Care plans are personalised, specific and appropriate with goals and desired outcomes recorded, and are based on the assessed needs of the residents. Interviews with staff, resident and relatives confirm they receive safe and appropriate services. The clinical manager and staff interviews confirm staff have access to current best practice which contributes to staff meeting the needs and desires of the residents
ARC requirements are met.

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

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

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

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: Activities are appropriate to the needs, age, culture, and the setting of the service. Activities are planned and facilitated to develop and maintain strengths of residents that are meaningful to them. Activities include grooming e.g. manicures and hairdressing services, entertainment, crafts, games, religious celebrations, exercise and outings. The activities coordinators keep records of resident attendance and the activity assessments are reviewed at six monthly intervals. The 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: The residents' person centred care plans (PCCP) are evaluated in a comprehensive and timely manner, at six monthly intervals or sooner when required by the residents' needs. The residents reviewed have short term care plans (and amendments to the PCCP) reflecting changes in their condition. Evaluations are documented and resident-focused. Care plans are reviewed every six months, or as required. ARC requirements are met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>Residents receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. The services policies and protocols describe processes to manage safe and appropriate prescribing, administration, review, storage, disposal and medicines reconciliation which comply with legislation. Medicines received from the pharmacy are checked by the pharmacy and checked by the service provider on arrival at the facility. Medicines reconciliation is conducted by the GP when residents are admitted to the service or re-admitted after hospitalisation. There is no evidence of transcribing taking place in the service (confirmed in 12 medicine charts).</p> <p>Staff members responsible for medicine management are competent to perform the function for each stage they manage. Twelve registered nurses, two enrolled nurses and eight health care assistants are responsible for administration of medicines. All staff members complete competencies for administering medicines. Controlled drugs are kept in a locked safe within a locked room. The service maintains a register for the management of controlled drugs.</p> <p>There are two residents in the Acorn wing who self-administer medicines. The facilitation of safe self-administration of medicines by residents is appropriate. Medicine management information is recorded to a level of detail which include the charts being legible, timely three monthly reviews by the GP, allergies and sensitivities being recorded, photo identification of the residents, signatures and dates for all entries and discontinued medicines on the administration chart. ARC requirements are 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: 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 1.3.12.3 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines appropriate to the residents' needs. The residents who have additional or modified nutritional requirements or special diets have these needs met. Food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. The menus were last reviewed by the dietitian at the Oceania Care Group's support office in May 2013. The service have winter and summer menus which rotates every four weeks, confirmed during the interview with the cook. ARC requirements are met.</p>

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

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

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 1.4.2: 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
<p>Evidence:</p> <p>There is a current building warrant of fitness expiring 1 June 2014.</p> <p>Discussion with the clinical and quality manager confirms that last certification audit identified the facility to be at 106 available beds. At the time of last certification audit one rest home resident was residing in one upstairs bedroom. This resident was moved to another room at the facility due to safety concerns of using the stairs. The clinical and quality manager states decision was made by Oceania support office not to use the upstairs bedroom, bringing the number of available beds to 105.</p> <p>The clinical and quality manager states there are nine rooms at the facility deemed as rest home rooms only. The auditor sighted all nine rooms and evidences eight of the nine rooms have single door access and one of nine rooms has a wing door access (this room is used for storage). Of the eight rest home rooms that are occupied, seven are occupied by rest home residents and one room by a hospital resident. The single door access to these rooms allows for hoist access and all these rooms are big enough for mobility aids, hoist and two care staff. Interview with the hospital resident residing in the rest home deemed room was conducted and confirms staff are able to provide hospital level of care for that resident.</p> <p>The auditor was provided with email correspondence (22 November 2013) from HealthCERT to Oceania support office stating the facility is certified for 102 beds; 63 hospital and 39 rest home.</p> <p>The clinical and quality manager contacted Oceania support office on audit day to ascertain if a provisional audit should be conducted alongside the surveillance audit to review the 102/105 total capacity in terms of verifying the suitability for hospital or rest home care. The Oceania Support office did not wish for this to occur.</p>

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: PA Moderate

Evidence:

Last certification audit identified the call bell system to require an improvement and this remains following this surveillance audit. All residents' rooms, communal bathrooms and living areas have wall mounted call bells. The room identified to have no call bell system in the Acon wing of the facility at last certification audit is no longer used as a resident's bedroom, states the clinical and quality manager. There is an area requiring improvement around call bells to ensure all call bells are functional. Not all ARC requirements are met.

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: PA Moderate

Evidence:

Interview with the maintenance person was conducted in respect of call bells at the facility. Monthly call bell audits were sighted and all calls bells are tested and in working order at the last monthly check by the maintenance person.

Finding:

The auditor tested number of call bells in the hospital wing of the facility and one call bell was not working. The maintenance person was asked to test all call bells at the facility on audit day and it was found that six call bells were not working. Two of the six rooms with non-functioning call bells were not occupied. Call bells in two of the four occupied rooms were able to be fixed by the maintenance person on day of audit. The contractor was called out to fix the other two remaining non-functioning call bells in the two remaining occupied rooms, which were still not functioning when the audit was completed.

Corrective Action:

Provide evidence all call bells function to summon assistance.

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

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

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 services demonstrate that the use of restraint is actively minimised. The use of enablers is voluntary and the least restrictive option to meet the needs of the residents with the intention of promoting and maintaining the resident's independence and safety. The service maintains a restraint and enabler register.

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.)*

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

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

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

Attainment and Risk: FA

Evidence:

The service carries out surveillance for infection in accordance with agreed objectives, priorities, and methods as specified in their infection control programme. The organisation determines the type of surveillance required and the frequency with which it is undertaken. Surveillance is appropriate to the size and complexity of the facility. 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. The service reports on infection control issues on a monthly basis at the staff meeting and submit a written report to the facility manager.

The service participates in benchmarking through Oceania Care Group support office by submitting monthly reports.

The previous requirements for improvement relating to evidence of residents who are carriers of Methicillin-resistant Staphylococcus aureus (MRSA) identified in their person centred care plan is fully implemented.

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