

# Oceania Care Company Limited - Ohinemuri Care Centre

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Current Status: 16 April 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

Ohinemuri is part of the Oceania Group and provides rest home, hospital and dementia care for up to 68 residents. Occupancy on the day of the audit is at 66 with 25 residents in the hospital, 30 residents at rest home level care and 10 residents in the secure dementia unit.

The service has continued to maintain a comprehensive quality and risk management programme that includes management of complaints, incidents, accidents, hazards with a robust health and safety programme in place. The service is managed by an experienced business and care manager/registered nurse who has been in the position for 11 years. The business and care manager is supported by a clinical manager who provides oversight of the clinical care services.

A well-developed staff orientation and education programme is implemented with all staff working in the dementia unit having completed or are completing the dementia training.

Staffing is adjusted to meet the needs of residents and there is at least one registered nurse on duty at all times.

The audit has confirmed the use of five bedrooms as being able to be used for residents assessed as either rest home or hospital level care.

Four of four requirements identified at the previous audit have been addressed around planning for challenging behaviour and infection control.

An improvement is required to staffing in the rest home on afternoon shifts.

## Audit Summary as at 16 April 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

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

#### Consumer Rights as at 16 April 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 16 April 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 16 April 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 16 April 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 16 April 2014**

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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### **Infection Prevention and Control as at 16 April 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)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Oceania Care Company Limited		
<b>Certificate name:</b>	Oceania Care Company Limited - Ohinemuri Care Centre		
<b>Designated Auditing Agency:</b>	Health Audit (NZ) Limited		
<b>Types of audit:</b>	Surveillance Audit		
<b>Premises audited:</b>	Ohinemuri Care Centre		
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
<b>Dates of audit:</b>	<b>Start date:</b> 16 April 2014	<b>End date:</b> 17 April 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			66

## Audit Team

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

## Sample Totals

Total audit hours on site	24	Total audit hours off site	10.5	Total audit hours	34.5
Number of residents interviewed	6	Number of staff interviewed	18	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	9	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	69	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	3			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 Thursday, 24 April 2014

## Executive Summary of Audit

### General Overview

Ohinemuri is part of the Oceania Group and provides rest home, hospital and dementia care for up to 68 residents. Occupancy on the day of the audit is at 66 with 25 residents in the hospital, 30 residents at rest home level care and 10 residents in the secure dementia unit.

The service has continued to maintain a comprehensive quality and risk management programme that includes management of complaints, incidents, accidents, hazards with a robust health and safety programme in place. The service is managed by an experienced business and care manager/registered nurse who has been in the position for 11 years. The business and care manager is supported by a clinical manager who provides oversight of the clinical care services.

A well-developed staff orientation and education programme is implemented with all staff working in the dementia unit having completed or are completing the dementia training.

Staffing is adjusted to meet the needs of residents and there is at least one registered nurse on duty at all times.

The audit has confirmed the use of five bedrooms as being able to be used for residents assessed as either rest home or hospital level care.

Four of four requirements identified at the previous audit have been addressed around planning for challenging behaviour and infection control.

An improvement is required to staffing in the rest home on afternoon shifts.

### Outcome 1.1: Consumer Rights

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family. Staff ensure residents are informed and describe how residents have choices related to the care they receive.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

### Outcome 1.2: Organisational Management

Services are planned, coordinated, and are appropriate to the needs of the residents. Day-to-day operations are being managed efficiently and effectively with the business and care manager and clinical manager providing operational and clinical oversight respectively. This ensures the provision of timely, appropriate and safe services to the residents. Quality and risk management processes are documented and maintained, reflecting the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and are reported to those affected in an open manner.

Human resources processes are managed in accordance with good employment practice. Education and training needs are being met by the organisation. Residents receive appropriate services from suitably qualified staff including staff in the dementia unit who have completed or are completing dementia training.

An improvement is required to staffing on the afternoon shift in the rest home area.

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

The residents' records provide evidence that all residents have been assessed. The service provider has well implemented system to assess, plan and evaluate the care needs of the residents. The residents' needs, outcomes and/or goals have been identified and these are reviewed on a regular basis with family input. A multidisciplinary approach to care is provided and reviews occur six monthly. One area identified in the previous audit in relation to strategies being documented on the personal care plans for individual residents in the dementia unit has been addressed appropriately and staff can follow the interventions suggested should there be any incidents of challenging behaviour.

Medication management is safely implemented. A visual inspection of the medication systems and the medication round at lunchtime evidences compliance with respective legislative requirements, regulations and guidelines and service agreement obligations. There is evidence of the four contracted general practitioners reviewing medication records three monthly or sooner if required. The general practitioner interviewed commented on the excellent relationship and communication between the nursing staff, pharmacy and the general practitioners in relation to providing a safely implemented medication system.

The activities programme is well implemented for the rest home, hospital and the dementia unit. Participation is voluntary but encouraged. Activities are meaningful and the programme is developed and implemented to ensure the interests of residents are included. Outings in the community are arranged and entertainers from the community are very welcome to participate in the programme. The programme is displayed in the reception area and covers the needs of the residents incorporating a holistic approach to all activities provided.

Food services policies and procedures are appropriate for this aged care residential service. The menu plans have recently been reviewed by the organisations national dietitian and the winter menu has commenced. The menu plans are suitable for the elderly and/or disabled residents. The menus are documented and displayed daily. The individual assessed needs identified during the assessment process for each resident on admission are addressed and choices are provided. Modified diets are made available to residents with assessed special requirements. Meals are provided at appropriate times of the day. All staff working in the kitchen have received full training on safe food handling and infection prevention and control.

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

Ohinemuri holds a current building warrant of fitness which expires on 31 May 2014. The audit has confirmed the use of five bedrooms as being able to be for residents requiring rest home or hospital level care.

### **Outcome 2: Restraint Minimisation and Safe Practice**

The service has clearly described restraint minimisation and safe practice policies which comply with the standard. There are three restraints used in the hospital and six enablers are in use. Staff have received training in de-escalation techniques for managing difficult or challenging behaviour and education in regards to the service policy, regulations and safe and effective alternatives to restraint. The staff in the dementia unit are well trained in dementia care and management and strategies are documented on the individual person centred care plan for each resident on how best to manage each situation should this occur. Also information is appropriately documented on the restraint monitoring form reviewed. Staff interviewed understand that the use of enablers is a voluntary process along with approval and informed consent processes. Maintaining resident independency and Safety is paramount at all times.

### Outcome 3: Infection Prevention and Control

The infection prevention and control policies and procedures implemented by the service reflect accepted good practice and infection prevention and control principles in care delivery. There are adequate resources to allow for a managed environment which minimises the risk of infection to residents, staff and visitors. The programme is relevant to the size and scope of the service and surveillance monitoring occurs and is monitored by the infection control co-ordinator. Monthly surveillance infection surveillance data is recorded, collated, benchmarked and reported to management. Three areas identified for improvement in the previous audit have been addressed in relation to the infection control committee having regular meetings, an infections control co-ordinator has been appointed and the infection control register is now accurately maintained.

### Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	15	0	1	0	0	0
<b>Criteria</b>	0	40	0	1	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	34
<b>Criteria</b>	0	0	0	0	0	0	0	60

### Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Low	Six of six health care assistants, the clinical manager, two registered nurses state that cares are completed but staff state that they are always rushed to complete tasks. A review of the rosters and staffing levels indicates that all shifts have sufficient staff apart from the rest home afternoon shift which has a health care assistant from 3pm-11pm and one from 4.30pm to 9pm. Currently there are four hospital residents in the rest home area (a total of 30 rest home residents – swing beds occupied). If the health care assistant on the long shift takes a tea break or both staff are engaged with one resident e.g. a hospital resident, then potentially there are no staff in the dining room or able to answer bells in a timely manner. Staff can ask others to help if needed e.g. from the hospital or dementia unit.	Ensure that there are sufficient staff on the afternoon shift in the rest home.	60

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## 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:**

An open disclosure policy and procedures is in place. The open disclosure policy identifies the services committed to the provision of safe, quality health care to the residents and community it serves.

The business and care manager operates an open door system as confirmed by resident and family interviews.

Family confirm they are kept informed of any concerns or changes to their relative's care. This is clearly shown on incident and accident forms sighted (28 reviewed) and as documented on communication notes in resident files (six files reviewed including two rest home, two hospital and two dementia unit). All resident files reviewed evidence communication to the resident's family about any significant changes to the resident.

Family members in the dementia unit particularly commented on the value of information provided and state that staff make every attempt to explain things to residents.

All bedrooms in the dementia unit are single rooms, and there is a quiet room in the dementia unit. There are quiet spaces in the hospital and rest home areas including a lounge which has been refurbished since the last audit to include a box of children's toys, wide screen television and lounge furniture. This is used as a family room.

Interpreter policies and procedures detailing access to interpreting services is available. Interpreters are usually accessed through the DHB if required.

There are no residents currently requiring the use of an interpreter and the business and care manager states that there have been no interpreters required since the last audit.

Six residents (three hospital and three rest home) and seven family members (three hospital, three dementia unit and one rest home) interviewed state that staff have sufficient time for discussions, appropriate space for discussion is available and that they are given time to talk about the care they are receiving.

Information is given to the resident and/or family in a timely manner as confirmed in interviews with six of six residents and seven of seven family members.

The district health board contract 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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisation has a comprehensive complaints process in place. It complies with Right 10 of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).  
All complaints are reviewed at management level by the business and care manager and the clinical manager as relevant.  
The business and care manager has an open door policy and both the business and care manager and the clinical manager are visible so that residents and family feel comfortable to discuss any concerns, issues or complaints at any time.  
Complaints forms are accessible for anyone requiring these at the entrance. There is also a complaint form for lost clothing that goes to the laundry for staff to follow up.  
Interviews with residents and family members confirm their awareness of where to find the complaints forms and how the complaints procedure works. One family member interviewed reports that they have made two complaints in the past with health care assistants supporting them to make the complaint. Both have been resolved in a timely manner and to the resident's satisfaction and both are on the register.  
There is a complaints register and a review of two complaints indicate that these are resolved according to timeframes outlined in the Code and policy. The restraint register summarizes the complaint category (communication, care/treatment, environment, consumer rights, hotel services and miscellaneous. There is a complaint summary, resolution, date, reviewed/audited and resolved.  
The district health board contract 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):** *(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.

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

## Outcome 1.2: Organisational Management

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The vision is 'to be the provider of choice for senior New Zealanders of care and lifestyle options in a way that meets and exceeds the expectations of our residents, staff and stakeholders'. The service provided aligns with requirements of the service agreement and relevant law i.e. there is comprehensive insurance cover for the business. The philosophy is 'It doesn't matter where you work or what you do, you are always expected to live the Oceania values of respect, excellence, passion and delivery and speak out when you feel these values are being compromised'. The philosophy and values were reviewed in June 2012.</p> <p>There is a business strategy and quality plan 2013 – 2014 (sighted) with goals and targets including service delivery, occupancy, staff and HR, quality reviews and projects, business and financial. The business and care manager completes a business status report monthly and this informs the executive management team of financial performance, revenue, healthy workplace, services and choice, resident connect, family connect, relationships and market presence, competitive analysis, physical products.</p> <p>Ohinemuri is certified for 68 beds of which 66 are occupied – 30 of 34 rest home (seven are swing beds), 10 occupants of 12 bed dementia unit and 26 hospital residents of 22 hospital beds.</p> <p>The business and care manager has over 20 years experience in aged care including management of a home care service and is a registered nurse (with a current annual practicing certificate) with a certificate and diploma in business studies. An interview with the business and care manager and a review of the employee file shows attendance at appropriate education / training sessions and a current practising certificate. Staff interviewed confirm that the business and care manager is available after</p>

hours.

Six of six residents and seven of seven family members state that the business and care manager is known to them and is approachable.

The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

The audit has confirmed that there are five bedrooms currently identified as rest home beds that are confirmed as being able to be used for hospital residents. Three are in the west wing. Two are opposite two shower/toilet wet areas with a large hallway that includes handrails. Both wet areas can include shower beds, hoists, hospital level shower chairs and at least two staff. The third room in the west wing is a larger room with french doors onto an internal courtyard that has access also to the lounge/reception area. All three rooms are also close to six bedrooms already identified as swing beds. One bedroom in the east wing has an ensuite and french doors onto the same internal courtyard. The room is large and has a wider door than others with a sliding door into the ensuite. Rails are already in the hallway and bathroom area. The fifth bedroom is in the east wing, is close to the hospital wing and opposite a wash room and toilet. While this currently accomodates a hoist and one person, there is arleady sign off that the two rooms are to be converted to a wet area with a shower, toilet and hand basin. Sign off for this to go ahead with approval is sighted - dated 26/3/14. The dates are set for the builder, plumber and vinyl layer (sighted) and they have delayed construction until after Easter. There is currently a rest home resident in the room and there is no intention of changing the resident to hospital level care at any point and the business and care manager confirms that the room will not be used as a hospital bed until after the wet area is completed.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>The service has Oceania policies and procedures and associated implementation systems to provide a level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>Interviews with six health care assistants (two who work in the dementia unit, two in the hospital, one in the rest home and one that floats between the rest home and hospital with three who work across all shifts including afternoons and nights), two registered nurses, the clinical manager and the business and care manager confirm that new or reviewed policies are discussed at meetings and confirm that this is a successful method for communicating changes to policy.</p> <p>There is a quality and risk management programme being implemented at Ohinemuri that includes an implemented internal audit programme. Audit summaries and action plans are completed where a noncompliance is identified with evidence of resolution of issues.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and managing this population appropriately. After each fall, there is a post falls analysis completed as sighted in a review of incidents and accidents.</p> <p>Resident/relative satisfaction surveys are completed annually with positive feedback provided in the 2013 survey. Actions are identified and followed through as required. Monthly meetings are in place that include health and safety, quality, and infection control; two monthly registered nurse and general staff meetings; weekly activities meeting as there are new activities coordinators in the service, daily head of department catch ups and kitchen staff meetings when required.</p> <p>All aspects of the quality and risk management programme are reported through all meetings including review of incidents and accidents, complaints, internal audit reports. Staff ensure that they read all minutes.</p> <p>There is a benchmarking process monthly across Oceania with the business and care manager and the clinical manager reviewing all data.</p> <p>Key improvements in the service has been review of the cultural and spiritual journey, resident nutrition, resident hygiene, the Oceania Connect recognition and award project and a train the trainer project. Data and review of each quality improvement project shows that there have been improvements made to the service.</p> <p>The district health board contract requirements are met.</p>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service collects incident and accident data. The incident/accident form provides an account of the incident; what actions were taken in response; who and when people were informed; any detail that will assist in determining how the incident occurred; and what actions were taken/are required to prevent recurrence. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Twenty-eight of 28 incident forms reviewed across the service demonstrated relevant follow-up. Discussions with the business and care manager confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications. Seven of seven family members interviewed state that they are always informed of incidents and 28 of 28 incident forms reviewed indicate that family are informed appropriately. The general practitioner interviewed states that improvements over the past four years around reporting of incidents to the medical team has improved the service considerably. The district health board contract 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.

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Current annual practising certificates for the clinical manager, registered nurses and enrolled nurse are sighted. Practising certificates are also available on-site for the podiatrist, pharmacist, occupational therapist, dietician and general practitioners.

Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files randomly selected for review (business and care manager, clinical manager, health care assistant, cook, registered nurse, activities coordinator) show that all staff files audited include up-to-date performance appraisals completed annually for staff.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. registered nurse, support staff, kitchen staff) and includes documented competencies. New staff are buddied with an experienced health care assistant during their induction programme as confirmed by a health care assistant who has been in the service for three weeks. Completed orientation checklists are documented on six of six staff files with nine of nine training records also sighted. Staff interviewed are able to describe the orientation process and report that new staff are adequately orientated to the service.

Discussions with staff and management confirm that an in-service training programme is in place. In-service training for 2013 and 2014 includes challenging behaviours, fire and emergency training, informed consent, infection control, food services, health and safety, pain management, code of rights, advanced directives, complaints, death and dying, abuse and neglect, delirium/dementia/depression, medication, aging process, falls management, cultural safety, manual handling. The workshops are offered at least twice at different times of the day so that staff working in the afternoon and at night can access training.

Staff hold current first aid certificates and the business and care manager confirms that there is always a staff member on site with a first aid certificate.

A competency programme is in place with evidence of annual medication competencies for the registered nurses, enrolled nurse and senior health care assistants with these sighted on the six relevant files reviewed. A spreadsheet of all completed competencies is maintained indicating that all staff have completed annual relevant competencies.

The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

There are 38 health care assistants. Of the 38 health care assistants, nine work in the dementia unit. Of the nine, seven have completed dementia unit training and two are completing it. The business and care manager and two activities staff including the activities coordinator who works in the dementia unit have completed the spark of life training. Three registered nurses and one enrolled nurse who oversees the dementia unit have also completed dementia training.

The district health board contract 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:**

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>There is a safe staffing policy that aligns with contractual requirements and includes skill mixes. There is a total of 69 staff including the business and care manager, clinical manager, nine registered nurses, one enrolled nurse, two cooks, 30 hours maintenance with a contract gardener, six kitchen assistants, one administrator, two cleaners, three laundry, 38 health care assistants, four activities coordinators who also provide an activities programme for day stay residents.</p> <p>An occupational therapist from Thames hospital oversees the activity programme.</p> <p>A physiotherapist is contracted in on a weekly basis and there is a physiotherapist assistant who provides 14 hours for the role.</p> <p>The sighted rosters in 2014 indicate that staff are replaced when on leave.</p> <p>Staffing is as follows (66 of a potential 68 residents):</p> <p>Rest home:</p> <p>AM: Three health care assistants (full shift) and two health care assistants short shift. There is a one servery staff member who serves breakfast. PM: One full shift and one health care assistant 4.30pm to 9pm. Night: Two health care assistants full shift.</p> <p>Hospital: Two health care assistants full shift and two health care assistants short shift. PM: one health care assistant full shift and two short shift (5pm-9pm and 5pm to 7pm). Night: One health care assistant full shift. There is a registered nurse on duty on all shifts.</p> <p>Dementia: There are two health care assistants full shift and the enrolled nurse and clinical manager oversight with hands on care provided PM: two health care assistants full shift with one overnight. Three family members, the enrolled nurse and the health care assistant in the dementia unit state that there are sufficient staff on all shifts noting that the health care assistant usually does night shifts and is the only staff member on. The health care assistant accesses support from the hospital and rest home when needed and states that staff always relieve and provide support.</p> <p>The service does not use agency staff noting that if absolutely necessary, then agency staff can be accessed from Hamilton.</p>

This audit has confirmed that there are five bedrooms currently rest home level that are able to be used for hospital level care. Staffing has been documented for hospital/rest home/dementia level care with a one staff to four hospital residents, one staff to 10 residents for rest home level care and one staff to six residents in the dementia unit not including clinical oversight. The business and care manager adjusts the staffing ratio according to the number of rest home and hospital level residents and will continue to do this with the increase in the five swing beds as they are filled with hospital residents.

Two health care assistants in the hospital interviewed state that there are just enough staff to manage cares on all shifts and this is confirmed by three residents and three families in the hospital interviewed.

The six health care assistants and two registered nurses interviewed state that there are just enough staff to complete tasks but that they are always rushing in the rest home area on afternoons. Three rest home residents and one family member with family in the rest home state that at times residents have to wait for bells to be answered on the afternoon shift. A review of the staffing for acuity meets needs of residents apart from a gap identified on the afternoon shift in the rest home where there are 30 rest home residents and four hospital residents (swing beds) currently. Potentially there are times on the afternoon shift when both health care assistants may be involved in supporting one resident or a health care assistant on a tea break and others will be left in the dining area potentially unsupervised apart from a kitchen hand who works until 7pm. The kitchen hand does not leave the dining area until after the last person leaves and can call for help if needed. One family member in the rest home states that at times family have to help residents as both health care assistants are busy with another resident. After the last certification audit, the business and care manager extended health care assistant hours. The pilot confirmed that extra staffing was needed from 4.30pm to 9pm and this shift has continued. The business and care manager continues to review staffing levels as acuity increases and decreases.

An improvement is required to staffing on an afternoon shift in the rest home.

The district health board contract 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:** PA Low

**Evidence:**

There is a safe staffing policy that aligns with contractual requirements and includes skill mixes. There are staff allocated to each area (rest home, hospital and dementia unit) and on the whole, there are sufficient staff to manage the acuity of residents.

The business and care manager provides oversight of the staffing and adjusts on a daily basis depending on acuity of the service.

**Finding:**

Six of six health care assistants, the clinical manager, two registered nurses state that cares are completed but staff state that they are always rushed to complete tasks. A review of the rosters and staffing levels indicates that all shifts have sufficient staff apart from the rest home afternoon shift which has a health care assistant from 3pm-11pm and one from 4.30pm to 9pm. Currently there are four hospital residents in the rest home area (a total of 30 rest home residents – swing beds occupied). If the health care assistant on the long shift takes a tea break or both staff are engaged with one resident e.g. a hospital resident, then potentially there are no staff in the dining room or able to answer bells in a timely manner. Staff can ask others to help if needed e.g. from the hospital or dementia unit.

**Corrective Action:**

Ensure that there are sufficient staff on the afternoon shift in the rest home.

**Timeframe (days):** 60 (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:**

There are policies and procedures in place to identify how residents receive timely, competent and appropriate services to meet their needs as identified in the assessment processes. The registered nurses and the clinical manager interviewed separately identified the development of the long term person centred care plan is to be a transparent partnership process. The clinical charge nurse or the registered nurses work collaboratively with the resident and the resident's family/whanau, advocate or other healthcare providers to complete, the person centred care plans (PCCP) sighted. The initial person centred care plan is documented within twenty four hours of admission taking into consideration the Needs Assessment Service Co-ordinators assessment (NASC), geriatrician at Health Services for Older Persons (HSOP) at the WDHb and/or psychological assessments from mental health specialist services for older persons (MHSOP) at the WDHb and the admission assessment for this facility. The long term person centred care plan is developed within three weeks of admission. The six of six resident files randomly sampled and reviewed (include two rest home, two hospital and two dementia unit) have all been reviewed six monthly or more often if required. There is clear involvement and evidence of the consultation sought with the resident, the multidisciplinary team, resident's family/whanau and/or advocate. Seven of seven family members interviewed verified that they are always invited to participate in the evaluations.

Handovers are provided by the registered nurses between each shift and the experienced health care assistants in the dementia unit. This process is overseen by the clinical manager.

Each stage of service delivery is undertaken by qualified and suitably skilled staff. All staff employed complete a staff orientation induction programme. The annual practising certificates for the eight registered nurses and one enrolled nurse employed are available and the business manager and care manager has a system in place to verify the APCs annually. The Annual APCs for the contracted health professionals is also maintained such as for the GPs, the pharmacists, the podiatrist, the dietitian, the physiotherapist and occupational therapist.

There is an appropriate education programme for staff that covers the essential components of the organisation and service delivery. A record of all participants is maintained for all in-service provided. A spread sheet records all competencies undertaken and this is available and sighted and is currently up to date.

The registered nurses are allocated residents as they are admitted to be responsible for the nursing assessment and development and implementation of the person centred care plans (PCCPs). A schedule is available to verify when they are to be individually reviewed. The general practitioners (four) conduct the medical assessments and reviews as per the agreement requirements. The healthcare assistants provide the majority of the personal cares for the residents. The GPs visit on a daily basis during the weekdays and are on call daily until 10pm Monday to Friday. The nursing staff can contact after hours Thames Hospital for advice or ring the ambulance service. The GP interviewed stated that is rare for a resident to be transferred after hours unnecessarily and also there is good communication between the nursing staff,

medical staff and the pharmacist. The clinical and non-clinical staff interviewed reported that team work is encouraged and continuity of care is promoted as discussed with the clinical staff more specifically.

There was an area of required improvement in relation to strategies to manage challenging behaviour and to ensure this is included in the person centred care plans for residents in the dementia unit. Two of two resident files evidence this is clearly documented on the monitoring forms and on the actual person centred care plans reviewed.

Tracer Methodology Rest Home:

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

Tracer Methodology Hospital:

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

Tracer Methodology Dementia Unit:

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

The ARRC requirements are met.

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

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

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

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

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

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

**Criterion 1.3.3.4 (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.

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

### Standard 1.3.6: 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:**

Interventions are clearly documented to ensure the identified needs of all residents can be effectively met and /or objectives achieved. Six of six resident person centred care plans reviewed evidence interventions that are consistent with and which contribute to meeting the assessed needs identified during the assessment process on admission or when the PCCP are reviewed. The care plans are reviewed six monthly or more often if there are any changes in the resident`s health status. Independence of all residents is encouraged or maximised. The care progress notes sighted record any current resident issues or changes observed in the course of the shift. The GP medical records are dated and signed appropriately and signatures can be verified. There are adequate continence and dressing supplies available in accordance with the service agreement and to meet the needs of the residents. Seven of seven family members interviewed confirm their family members current care needs are effectively met and that they are contacted if any changes in condition or incidents occur. The six of six files randomly sampled evidence referrals to other services such as outpatients clinics or the NASC service as required. The files have a family communication record sheet to verify communication with families as required. The care progress notes also verify this occurs.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are four activities co-ordinators employed for this service. One has completed the diversional therapist training. Each activities co-ordinator has a special function to meet the needs of the residents. The activities programme is well planned and executed. An occupational therapist oversees the programme. Equipment and resources are plentiful and storage is available. A cupboard is available in the dementia unit with lots of different resources for the evening and night times if residents are awake or present with challenging behaviour. Suggested activities are documented on the individual activities plans for each resident in the dementia unit as well to cover the twenty four hour period which is a contract requirement. At interview with the four staff responsible for this programme all are well informed and are passionate about their individual roles. Attendance records are maintained. Activities plans are developed and implemented for all residents individually. Activities are developed to maintain strengths and independence and are to be meaningful to residents. The service has a van with seating for nine residents and one wheelchair hoist for external outings in the community which are popular with the more ambulant residents. (The seating goes backwards) and this poses a problem for some residents. Designated drivers have their licences reviewed and sighted by the business and care manager. Participation is voluntary but encouragement is given to residents on a one on one basis if required or group activities are encouraged and promoted for those who are able to join in. Families are welcome to participate. The individual activities plans are reviewed at the same time as the care plans are reviewed. Input from the activities co-ordinators is sought for the multidisciplinary reviews. Interviews with seven of seven residents confirm their individual preferences as whether to participate in the activities programme or not.

The ARRC 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:**

Care progress notes are evaluated each shift and at each point of contact with the residents. The person centred care plans are reviewed six monthly or more often if and when required. Evaluations are evident in the six of six resident files sampled (two rest home, two hospital and two dementia unit) and all are dated and signed off appropriately. Staff designations are recorded. The registered nurses are responsible for the PCCP reviews. Multi-disciplinary reviews occur six monthly with input from the team inclusive of the GP, physiotherapist, activities co-ordinator, registered nurse, health care assistants, family and others. The clinical manager reviews the PCCPs in the dementia unit for each resident. Interventions are changed accordingly to ensure the objectives or goals set can be achieved.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The 12 of 12 medication records were randomly reviewed four rest home, four hospital and four dementia unit. All records reviewed are documented clearly and the name, dates and signatures are documented. Signatures can be verified. Staff designations are included as necessary. Evidence of staff responsible for medication management is available and a spread sheet with all relative competencies being completed is able to be verified. Medication in all three areas rest home, hospital and dementia unit and is stored appropriately. The medication rooms are locked securely. Fridges are monitored and recordings available. The controlled drugs are checked with the clinical manager and balances are documented. The registered nurses interviewed check the drugs weekly and stock checks are documented. Policies and procedures are available to guide staff and in particular in relation to control drug management inclusive of ordering controlled drugs, receiving controlled drugs from the contracted pharmacy, storage and checking controlled drugs. There is a procedure for reporting any incidents related to medication management and safe practice. Prescribing, disposal and reconciliation of medicines are in line and meet with legislative requirements and appropriate guidelines used in this aged care setting. Medication trollies are available for each area of service delivery and the medication round was sighted in the dementia unit. Two registered nurses interviewed have received training in medication management in relation to diabetic patients, palliative care and other speciality areas. Education is documented on the training programme for medications and audits are performed several times annually April, July and October on all aspects of medication management to ensure safe practice occurs at all times. The GP interviewed stated that there are minimal medicine incidents with the newly implemented robotic system. Evidence of the three monthly medication reviews are evident and the GPs sign in the appropriate place on the medication sheet sighted. The 12 of 12 medication records evidenced that all residents are consulted as to whether they have any known allergies or sensitivities to be recorded. Known allergies are recorded on the medication record and the clinical notes and highlighted with an alert sticker. "Nil Known" evidences they have been consulted. No residents are currently self-medicating medication but processes are in place should this be required.

The ARRC requirements are met.

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

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

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

**Criterion 1.3.12.3 (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.

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  <p>The service has a summer and winter menu. The menu plans have recently been reviewed by the organisations national dietitian and a letter was sighted to verify this has occurred. The new winter menu has been commenced on the 07 April 2014. The menus are four weekly cycles and the menu is displayed in the kitchen and in the main reception area. The review indicated that the menu is suited to the older person living in residential care. An interview with the experienced cook indicates that the menu is modified for those requiring pureed food and there is always food available for the twenty four hour period in the dementia unit. The nutritional needs of the residents are met by observations, interview with the cook and interviews with six of six residents and seven of seven family members. Fluids are readily available. Residents are weighed monthly or more frequently if medically required or ordered by the dietitian or the doctors.</p> <p>Breakfast, lunch and tea are served at appropriate times with morning tea, afternoon tea and supper being provided. The registered nurses complete a nutritional</p>

assessment when residents are admitted and any preferences or dislikes, allergies to food are recorded and given to the cook for the kitchen staff to be aware of when providing the meal service. A copy is retained in the resident's individual file sighted. The cook interviewed has a good understanding of special diets required and meeting the individual needs of the residents. The cook is supported in the kitchen with a kitchen hand. The main dining room is situated near the kitchen. The food for the dementia unit and hospital is transported in a heated bain-marie and served in both areas by staff. All kitchen staff have completed relevant courses and food hygiene certificates. The kitchen is clean and well equipped. The cook and kitchen hand are attending a one day update 'Introduction to Food Safety Management Programme' on the 13 May 2014 run by the organisation. The current cook has worked in the kitchen for six years but has only been in this position for four months. A cook covers the weekend and is available to cover the full time cook for annual leave or sickness.

Food temperatures are monitored daily at lunchtime and tea time. Residents were observed enjoying the food at lunchtime. Adequate staff is available during this meal time sighted. Equipment is available if needed including lipped plates and special drinking cups. All fridges and freezers including the walk in chiller and walk in freezer are adequately monitored and temperature records are maintained. Checks are done on a daily basis. The cook is responsible for all aspects of food procurement, production, preparation, storage, transportation within the facility, delivery and delivery checks and disposal ensuring this complies with current legislation and Ministry of Health Guidelines and Local body (Council) requirements.

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

#### **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:**

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

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The building warrant of fitness (BWOFF) expires on 31 May 2014.

All seven of seven residents interviewed expressed satisfaction with the facility and on-going maintenance.  
The District Health Board contract 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.

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

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>There are policies and procedures that define all types of restraint and enablers in ways that meet this standard. Processes are in place at both governance and facility level for determining restraint approval. Staff interviewed and resident files sampled evidence responsibilities are clearly identified and known. Resident files sampled evidence family/whanau input into the restraint approval process and the restraint co-ordinators (2) and the general practitioner review the process.</p> <p>There are three hospital level residents currently using a restraint and six residents using enablers. The two restraint co-ordinators job share this role for this service. One co-ordinator is available for interview and has a good understanding and knowledge of restraint management and safe practice (RMSP). Education is provided to all staff at orientation and is ongoing with an annual questionnaire to be completed. Training records sighted record de-escalation training occurred in February 2014 and restraint</p>

is scheduled on the programme for august 2014. All staff received education in 2013 and a record is retained in each staff member's individual file. Six of six staff files were reviewed. A quality audit is scheduled for restraint July 2014.

Dementia unit:

Policy relating to minimising the use of restraint and management of disturbed and/or challenging behaviour in accordance with the requirements of the service agreement are met. Ongoing education is provided and all staff employed in the dementia unit are fully trained with the exception of two newly employed health care assistants who are currently receiving training on dementia care.

Staff interviews evidenced staff have a good knowledge of enabler use and that this shall be a voluntary and the least restrictive option to meet the needs of a resident with the intention of promoting or maintaining resident independence and maximising safety.

The ARC requirements are 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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Results of surveillance are acted upon, evaluated and reported to relevant personal in a timely manner. Surveillance monitoring is the responsibility of the infection control co-ordinator (ICC), the registered nurse clinical manager appointed to this role. This includes an audit of the facility next due May 2014, hand hygiene and surveillance of infection control events and infections. The infection control co-ordinator is responsible to the business and care manager. There is an infection prevention and control register sighted in which all infections are documented monthly. Infections treated or untreated are clearly documented on the infection control register (this was an area of required improvement in the previous audit). The infection control committee consists of the ICC, a cleaner, a rest home hospital care assistant, one activities/physiotherapist aide, a hospital health care assistant, and a laundry staff member when available. Meetings occur two monthly and minutes of the meetings sighted are maintained (this is an area of required improvement from the previous audit).

Surveillance covers respiratory, urinary, skin, eye, ear, mouth and wound infections. A monthly infection report is completed and a comparative summary is completed of all facilities in the organisation as part of the benchmarking programme. Graphs are provided in diagrammatic form with summaries and are sent back to the facility from head office and the three areas, rest home, hospital and dementia unit are clearly documented in relation to surveillance. No trends or outbreaks of infection have occurred or been identified since the last audit. The infection control report inclusive of surveillance performed is collated by the infection control co-ordinator and is reported to the business and care manager. Infection control is closely linked to the health and safety and to the quality and risk management system for this service. The three areas of required improvement in relation to the previous audit (3.4.1 & 3.5.3 and 3.5.7) have been effectively met.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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