# Oceania Care Company Limited - Middlepark Rest Home & Village

## Current Status: 25 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.

Middlepark Rest Home provides care for up to 61 residents at rest home level care. On the first day of this unannounced surveillance audit there were 52 residents residing at the facility.

One area requiring improvement identified at the last certification audit that related to corrective action plans remains. The second area requiring improvement around residents’ risk assessments is fully met.

There are five areas identified requiring improvement around corrective action plans post surveys, staff in- service education, staff sign off on new policies and meeting minutes, activities plans and staff performance reviews.

## Audit Summary as at 25 March 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | 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 25 March 2014

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| 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. |

### Organisational Management as at 25 March 2014

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| 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. |

### Continuum of Service Delivery as at 25 March 2014

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

### Safe and Appropriate Environment as at 25 March 2014

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| 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. |

### Restraint Minimisation and Safe Practice as at 25 March 2014

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| 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. |

### Infection Prevention and Control as at 25 March 2014

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

# 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**

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| --- | --- |
| **Legal entity name:** | Oceania Care Company Limited |
| **Certificate name:** | Oceania Care Company Limited - Middlepark Rest Home & Village |

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| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

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| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Middlepark Rest Home & Village |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 25 March 2014 | **End date:** | 26 March 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 52 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 4 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 10 | Total audit hours | 34 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 9 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 40 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 2 |

## **Declaration**

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

I confirm that:

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| 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, 3 April 2014

## **Executive Summary of Audit**

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| **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.Middlepark Rest Home provides care for up to 61 residents at rest home level care. On the first day of this unannounced surveillance audit there were 52 residents residing at the facility. One area requiring improvement identified at the last certification audit related to corrective action plans remains. The second area requiring improvement around residents’ risk assessments is fully met. There are five areas identified requiring improvement around corrective action plans post surveys, staff in- service education, staff sign off on new policies and meeting minutes, activities plans and staff performance reviews. |

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| **Outcome 1.1: Consumer Rights** |
| An open disclosure policy is documented and implemented. Interpreter services are available, if required. The complaints process is made known to residents and families on admission and displayed in the facility. Staff, residents and family interviewed demonstrate an understanding of the complaints process. A complaints register is maintained and up to date. |

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| **Outcome 1.2: Organisational Management** |
| Oceania Care Company, the governing body has systems in place which define the scope, direction and goals of the organisation and the facility, and the monitoring and reporting processes against these systems. Quality improvement data is reported on to the governing body monthly, via the intranet. Internal audits are conducted and where corrective actions are required this is documented and implemented. An area requiring improvement from the last certification audit around developing and implementing corrective action plans remains in respect of satisfaction surveys.Middlepark rest home is managed by a business and care manager, a registered nurse with aged care experience, who is supported by a clinical leader, a registered nurse and a clinical and quality manager from Oceania.The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is evidence in the residents’ files reviewed of adverse event reporting and this is also reported monthly to Oceania 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 staff orientation and in-service education and training. There are regular in-service education and training opportunities provided for staff, however some mandatory education has not been conducted and this requires an improvement. There are areas requiring improvement around staff performace reviews and staff sign off on new policies and meeting minutes.There is a documented rationale for determining staff levels and staff skill mixes.  |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Service provision is undertaken by suitably qualified and experienced staff members. Interview with the clinical leader confirms knowledge, understanding and experience of care of the elderly. Health care services are provided within time frames that safely meet the needs of the residents, however activity plan reviews are not currently completed within the required six months and this requires an improvement.Reviewed resident files are easily identifiable, initial care plans are in place, admission agreements are signed and dated, next of kin are identified and where a resident have an enduring power of attorney (EPOA) identified, the service holds legal documentation in support. Residents have consents signed and residents who are competent to make the decision, complete advanced directives.Progress notes are legible and comply with legislative requirements. The service record risk assessments for residents. Individual care plans include goals, interventions and six monthly reviews. Resident files reviewed have activity plans which include the resident’s interests and community based activities. The resident files show that where the progress of the resident is different from what is expected, the service acts by reviewing and changing the person centred care plan (PCCP) of the resident accordingly. The previous requirements for improvement relating to risk assessments to be conducted and recorded is fully implemented.Medicines management information is recorded to a level of detail that complies with legislation. The records are legible, doctor’s reviews are completed and entries and discontinued medicines are signed and dated. The residents’ medicine charts all have photo identification. The controlled drugs are kept in a secure manner. Controlled drug entries into the drug register are checked weekly by registered nurses and the pharmacy does a six monthly drug stock-take of controlled drugs. The service monitors the medicines fridge temperatures daily. The service has a process for returning medicines to the pharmacy. There are no residents self-administering medicines at the facility.The food, fluid and nutritional needs of residents are provided in line with recognised guidelines that are appropriate to the residents’ needs. The menus are reviewed annually by the dietitian from the support office. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| There is current building warrant of fitness. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service actively works towards minimising restraint. The responsibility for the restraint process is clearly defined and there are clear lines of accountability identified. There is no evidence of restraint being used in the facility at the time of the audit. The service has one resident using an enabler. Use of enablers is voluntary and the least restrictive options in order to meet the needs of the resident. |

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| **Outcome 3: Infection Prevention and Control** |
| The service carries out surveillance of infections. The infection control coordinator reports to the quality meeting at monthly intervals. 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. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 13 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 5 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 63 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.4 | 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. | PA Low | There is no recorded evidence of staff sign off in 2013, when staff have read new policies. This has commenced in 2014, sighted. Staff that are unable to attend meetings are not provided with minutes of meetings to read and sign. Interview with management confirms this. Staff room did not evidence staff meeting minutes for staff to read. | Provide evidence of staff sign off on new policies and staff meeting minutes. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | There was an area requiring improvement at last certification audit around documentation and implementation of corrective action plans. This finding remains following this surveillance audit.Resident menu survey was conducted in February 2013. Resident and relative satisfaction survey was conducted in July 2013. Both surveys were sighted and evidence results of surveys are collated, however there is no analysis of data, no evidence of corrective action plans and no evidence of communication of the survey results to residents, families and staff.There is evidence of deficits identified in the resident and relative satisfaction survey around information sharing, Code of Rights, incident/ accident reporting, care plan reviews, activities programme and the laundry service. The resident menu survey identified six deficits out of six questions.The Oceania satisfaction survey policy records survey outcomes are to be reviewed and corrective action plans put in place with definite timeframes and personnel assigned to these achievements and the survey outcomes should be discussed at the monthly quality meetings.The quality meeting minutes reviewed for 2013 do not evidence discussions in respect of the survey results.  | Provide evidence of analysis of survey results, development and implementation of corrective action plans and communicating these findings to all concerned. | 180 |
| 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 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Seven staff files reviewed. One of seven staff files evidences performance review has not been conducted for that staff member (clinical leader). | Provide evidence of current performance reviews of all staff. | 180 |
| HDS(C)S.2008 | Criterion 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. | PA Low | i) There is no recorded evidence that all required mandatory education has occurred, such as abuse and neglect. Staff files reviewed do not evidence not all compulsory education sessions have been provided for staff.ii) The 2013 staff education plan was not available on audit day.iii) Some education sessions do not evidence staff attendance sheets, such as advance directives education (October 2013) and care planning education (February 2014). | Provide evidence mandatory staff in-service education is provided for staff and staff attendance sheets are maintained. | 180 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.7.1 | Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Three of the five resident files reviewed show evidence of the activity plans not being reviewed in a timely manner. | Activity plans to be reviewed six monthly. | 180 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies and procedures in place to support the open disclosure practice in the facility.Incident forms, residents’ progress notes and family communication forms evidence family are informed of adverse events or when resident’s condition alters, confirmed at seven of seven clinical staff interviews (one clinical leader/registered nurse(RN), three RNs, two health care assistants and one enrolled nurse (EN) .Residents (eight of eight) and family members (five of five) interviewed confirm that staff and management communicate well with them.The business and care manager advises there are no residents requiring interpreter services at time of audit. Admission agreement was sighted and contains all required information including full details of resident’s rights to receive or not receive additional services and charges for additional services. Service information in the form of an information pack is available and appropriate to the communication needs and capabilities of the residents, families and referring agenciesRelated 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The complaints policy and procedures are congruent with Right 10 of the Code of Rights. There is a complaints register, which is current and monitored by the business and care manager. Complaints registers for 2013 and 2014 were reviewed. The complaints registers record six complaints in 2013 and four complaints in 2014. There is evidence of records of the date the complaint was received, date of written acknowledgement sent, date the investigation was completed and if the complaint was resolved to the satisfaction of the complainant.There is evidence of the organisation taking action and improving services, as a result of a complaint, such as upgrading the telephone system and the call bell system. There is one complaint from 2013 that is currently still open, as the new phone system requires all staff to be educated in its use. The corrective action plan in relation to the new phone system has been developed and is in process of being implemented.Complaints procedure audit was last conducted in November 2013 with 100% compliance.Staff education on complaints processes has not been conducted (refer to criterion1.2.7.5).The complaints process documentation is included in the facility welcome and information pack and located at entrance to the facility.Eight of eight residents and five of five family members interviewed are aware of the complaints processes. Health and Disability Commissioner (HDC) brochures on Code of Rights and Learning from Complaints are displayed throughout the facility. The Nationwide Advocacy Service and the HDC contact details are also available at the facility. The business and care manager/RN and the clinical leader / RN state there has not been any complaints since the last certification audit, referred to the Health and Disability Commission, police, coroner, accident corporation or Ministry of Health.Related ARC requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Oceania Care Company Limited has systems in place, that 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 leader 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. The philosophy is in a form that is easily understood.Middlepark Senior Care business plan 2013 was sighted and the business and care manager states it is due for review in June 2014. The business and care manager is a registered nurse with current practising certificate and has been in this position at this facility for two weeks. The business and care manager has been working for Oceania group for three years, as a manager at another Oceania facility. They are supported in their role by a clinical leader / RN and Oceania quality and clinical manager. The business and care manager states they have completed the national diploma in business management and facility management diploma at Tai Poutini Polytechnic West Coast in 2012. The business and care manager states they participate in management and clinical professional development related to their position. The business and care manager’s file could not be sighted as it is located at Oceania’s support office.In the business and care manager’s absence the responsibility is delegated to the clinical leader/ RN.Prior to the current business and care manager’s commencement of employment, the facility was previously managed by the clinical leader in the role of acting facility manager. The Oceania quality and clinical manager interview confirms another clinical leader / RN was employed for approx 11 months, while the clinical leader was in the acting facility manager’s role. In January 2014 until the current business and care manager’s commencement of employment, the then acting facility manager returned to their role of the clinical leader and the facility was managed by a manager from another Oceania facility.All staff requiring practising certificates have current practising certificates, sighted. Audit of currency of practising certificates, first aid and drivers licences was conducted in March 2014 and evidences 100% compliance. Middlepark rest home has contracts with Christchurch District Heath Board (CDHB) for aged related residential care for rest home services and aged related residential respite care.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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are quality and risk management systems in place including clinical risk management policy and plan and quality improvement policy. There is on going surveillance and monthly reporting on clinical risks including accidents/incidents and sentinel events. There is a quality manager who is employed for four hours a week to conduct internal audits and develop and implement corrective action plans where deficits have been identified. An internal audit schedule and completed audits for 2013 and 2014 were reviewed. There is evidence internal audits results are collected, collated, evaluated, and analysed to identify trends and if corrective actions are required this is developed and implemented. Residents and family satisfaction survey was last conducted in July 2013 and menu survey was conducted in February 2013 and both surveys evidence the results are collated, however there is no evidence of actions taken in response to the survey results and this requires an improvement. Area requiring improvement from last certification audit around developing and implementing corrective action plans remains.Quality and risk management data and quality improvement data is reported at the quality improvement and staff meetings (refer to criterion 1.2.3.8). Monthly report of the facility clinical indicators are displayed in the staff room. Registered nurses meetings are conducted monthly. Sighted resident meeting minutes for January and March 2014. Minutes of meetings are not provided for staff who were unable to attend meetings and this requires an improvement. Policies and procedures reflect current accepted good practice and reference legislative requirements. Document control policy and procedure for new or reviewed documents is recorded and implemented. Staff interviews (two health care assistants, three registered nurses, one clinical leader, one quality manager and one enrolled nurse) confirm staff are informed of new / updated policies, however staff signing sheet did not demonstrate staff sign off and this requires an improvement. Health and safety manual documents health and safety management systems including health and safety policy and plan, employee participation, health and safety audits, accident reporting, injury management, hazard management, contractor management and emergency plan. Health and safety policy is displayed on residents’ notice board. Hazard registers are sighted and are current. Minutes of health and safety meetings are sighted.Oceania holds Workplace Safety Management Practices at tertiary level for ACC workplace safety and this expires on 31st March 2015. Heath and safety audit was last conducted in February 2014 with 100% compliance.ARC requirements are not fully 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.

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Oceania policies and procedures are provided by the Oceania support office. There is evidence new policies and procedures are sent to the facility. |
| **Finding:** |
| There is no recorded evidence of staff sign off in 2013, when staff have read new policies. This has commenced in 2014, sighted. Staff that are unable to attend meetings are not provided with minutes of meetings to read and sign. Interview with management confirms this. Staff room did not evidence staff meeting minutes for staff to read. |
| **Corrective Action:** |
| Provide evidence of staff sign off on new policies and staff meeting minutes. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

##### **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.

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Internal audits for 2013 and 2014 were sighted and evidence where deficits were identified, this was recorded and corrective action plans were documented and implemented. Audit schedules are followed and results of quality findings are discussed at monthly quality improvement meetings, sighted. |
| **Finding:** |
| There was an area requiring improvement at last certification audit around documentation and implementation of corrective action plans. This finding remains following this surveillance audit.Resident menu survey was conducted in February 2013. Resident and relative satisfaction survey was conducted in July 2013. Both surveys were sighted and evidence results of surveys are collated; however there is no analysis of data, no evidence of corrective action plans and no evidence of communication of the survey results to residents, families and staff.There is evidence of deficits identified in the resident and relative satisfaction survey around information sharing, Code of Rights, incident/ accident reporting, care plan reviews, activities programme and the laundry service. The resident menu survey identified six deficits out of six questions.The Oceania satisfaction survey policy records survey outcomes are to be reviewed and corrective action plans put in place with definite timeframes and personnel assigned to these achievements and the survey outcomes should be discussed at the monthly quality meetings.The quality meeting minutes reviewed for 2013 do not evidence discussions in respect of the survey results.  |
| **Corrective Action:** |
| Provide evidence of analysis of survey results, development and implementation of corrective action plans and communicating these findings to all concerned. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy on incident/accident and sentinel event reporting. 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 process.Sighted documentation around a sentinel event that occurred in December 2013 and there is evidence of completed sentinel event investigation form and plan. This information was communicated to the support office and Oceania clinical and quality manager and and the sentinel events summary report to the Board of Directors.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 conduced in September 2013, and corrective actions identified at this audit were addressed.Related ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are policies and procedures in relation to human resource management. Annual practising certificates are current for all staff who require them to practice.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 this is used alongside the clinical in-service sessions provided at the facility. Education audit was conducted in February 2014 with 100% compliance.An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. All staff who are in direct contact with residents have completed education that is related to the care of older people. The staff who have not completed the training at appointment have completed apropriate training within six months of appointmentStaff interviews confirm orientation / induction is provided for new staff. Care staff also confirm their attendance at on-going in-service education. There are two areas requiring improvement around staff in-service education and staff performance reviews.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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Seven staff files reviewed evidence all processes are followed as per human resources policies and procedures except currency of performance reviews. |
| **Finding:** |
| Seven staff files reviewed. One of seven staff files evidences performance review has not been conducted for that staff member (clinical leader). |
| **Corrective Action:** |
| Provide evidence of current performance reviews of all staff. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.7.4 (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.

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a planned and documented staff in-service education plan for 2014. |
| **Finding:** |
| i) There is no recorded evidence that all required mandatory education has occurred, such as abuse and neglect. Staff files reviewed do not evidence not all compulsory education sessions have been provided for staff.ii) The 2013 staff education plan was not available on audit day.iii) Some education sessions do not evidence staff attendance sheets, such as advance directives education (October 2013) and care planning education (February 2014). |
| **Corrective Action:** |
| Provide evidence mandatory staff in-service education is provided for staff and staff attendance sheets are maintained. |
| **Timeframe (days):** 180 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are documented staffing rationale policies for determining staffing levels and skill mixes. Staff interviews confirm staff are able to get through their work. Residents interviewed state the care they receive is appropriate to their needs.There is evidence there are two registered nurses (RN)’s and two enrolled nurses (EN)s employed in the facility additional to the business and care manager /RN and the clinical leader /RN.Rosters evidence business and care manager and the clinical leader work Monday to Friday and are on call after hours, shared with RNs. There is a registered nurse cover for 40 hours a week, additional to the business and care manager and clinical leader. RNs are rostered on for 40 hours a week on morning shifts and two ENs rostered for 56 hours a week for a mix of morning and afternoons shifts. There is a RN cover on morning shifts in the weekends.The least amount of staff occurs on the night shift with two health care assistants.ARC requirements are met. |

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

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

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

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

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

#### Standard 1.3.3: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Service provision is undertaken by suitably qualified and experienced staff members. Interview with the clinical leader confirms knowledge, understanding and experience of care of the elderly. Health care services are provided within time frames that safely meet the needs of the residents, however activity reviews are not currently completed within the required six months (refer to criterion 1.3.7.1). Services are coordinated in a manner that promotes continuity in service delivery and promotes a team approach.Tracer methodology in the Rest Home: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*ARC requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents who are competent to make the decision, complete advanced directives and the resuscitation status of residents are identified. Staff members make entries to the progress notes during every shift. The service record risk assessments including falls, skin integrity, challenging behaviour, dietary assessments, oral assessments, cultural, wounds, continence pain and nutritional assessments.The individual care plans include goals, interventions and six monthly reviews. There is evidence of residents and or their family making input into care planning. Vital signs are recorded for residents and they have their weight monitored on a monthly basis. 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service employs an activities coordinator who works five days, seven hours per day in the service.Each resident file reviewed has an activities plan which includes the resident’s interests and community based activities. Activities are planned and facilitate the developments and maintenance of strengths that are meaningful to the residents. Resident files reviewed show evidence of the activity plans not being reviewed in a timely manner.ARC requirements are not fully met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The activities coordinator creates a monthly activities planner which is displayed in A3 format on the three notice boards around the facility and each resident receives a copy of the monthly planner. The activity coordinator keeps record of residents attending activities, sighted. Resident files reviewed show that the activity plans are not currently evaluated in a timely manner.  |
| **Finding:** |
| Three of the five resident files reviewed show evidence of the activity plans not being reviewed in a timely manner. |
| **Corrective Action:** |
| Activity plans to be reviewed six monthly. |
| **Timeframe (days):** 180 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident evaluations are documented and reflect the current status of the resident. Five resident files are reviewed. The resident files show that where the progress of the resident is different from what is expected, the service acts by reviewing and changing the person centred care plan (PCCP) of the resident accordingly. The previous requirements for improvement relating to risk assessments to be conducted and recorded is fully implemented.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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Medicines management information is recorded to a level of detail that complies with legislation. Ten medicine charts are reviewed. The records are legible, doctor’s reviews are completed every three months and each entry is signed and dated. Discontinued medicines are signed and dated and all residents have their allergy and sensitivity status identified. The residents’ medicine charts all have photo identification.Medicines reconciliation takes place for all new residents or residents that return to the service after hospitalisation. The controlled drugs are kept in a lockable safe in a locked medicines cupboard inside a locked medicines room. Controlled drug entries into the drug register are checked weekly by registered nurses and the pharmacy does a six monthly drug stock-take of controlled drugs. The service monitors the medicines fridge temperatures weekly. On the day of the audit a random sample of medicines expiry dates showed medicines are within the required use-by dates. The service has a process for returning medicines to the pharmacy. The clinical team leader and the business and care manager confirm there are no residents who self-administer medicines. Medicine competencies are recorded for five registered nurses, two enrolled nurses and nine health care assistants (HCA).Medicines management training last occurred in August 2013.ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The food, fluid and nutritional needs of residents are provided in line with recognised guidelines that are appropriate to the residents’ needs. The menus are reviewed annually by the dietitian from the support office and was last reviewed in October 2013.Residents who have special or additional nutritional needs have these needs met. The kitchen manager receive a copy of the dietary profile, completed on admission and when the residents’ needs change, confirmed during interview with the kitchen manager. Food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food stores are well stocked and tidy. Resident’s food preferences are identified and written on the kitchen manager’s white board on the inside of the pantry door, to ensure it is adhered to.Interviews with residents and their families confirm the food is of high quality, nutritional and they receive large enough portions during meals.ARC requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

##### **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.

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

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

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

#### Standard 1.4.2: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Building warrant of fitness is dated to expire on 1 June 2014. There have been no alterations or additions to the facility since last certification audit. |

# 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service actively minimise restraint. The responsibility for the restraint process is clearly defined and there are clear lines of accountability identified. The service maintains a process for approval of restraint should they ever need to implement restraint. There is no evidence of restraint being used in the facility at the time of the audit. The service has one resident using an enabler in the form of a lap belt.Use of enablers is voluntary and the least restrictive options in order to meet the needs of the resident. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service carries out surveillance of infections. The infection control coordinator reports to the quality meeting at monthly intervals. Surveillance include the date, the type of infections, symptoms displayed by the resident, the course of treatment and the date the infection is resolved. The surveillance data include respiratory infections, urinary tract infections (catheterised and non-catheterised residents) skin infections, gastro-intestinal infections, systemic infections and ear, nose, eye and mouth infections, confirmed during interview of the Infection Control Coordinator. 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. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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