Aspen Lifecare Limited

Current Status: 16 July 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Provisional 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

Aspen Rest Home provides residential care for up to 54 residents and occupancy on the first day of the audit was 38. The service provider is certified to provide rest home level care. The facility is currently operated by Oceania Care Company Limited. This provisional audit is undertaken to establish the extent to which the existing provider conforms to the requirements of the Health and Disability Services Standards and the district health board (DHB) funding contract prior to a change in ownership. This audit also establishes how well prepared the prospective provider is to provide a health and disability service. A representative for the prospective provider, Aspen Lifecare Limited, was interviewed during this audit. Residents and family members interviewed provide positive feedback on the care provided.

There are three areas identified during this audit that require improvement that relate to: development and review of corrective action plans to address shortfalls identified in service delivery; documenting progress towards meeting the resident's needs in their care plans; and repairs and maintenance to the building and furniture.

HealthCERT Aged Residential Care Audit Report (version 3.92)

Introduction

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

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

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

Audit Report

Legal entity name:	Aspen Lifecare Limited
Certificate name:	Aspen Lifecare Limited

Designated Auditing Agency:	Health Audit (NZ) Limited

Types of audit:	Provisional audit
Premises audited:	Aspen Rest Home
Services audited:	Rest home services
Dates of audit:	**Start date:** 16 July 2014 **End date:** 17 July 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	38

Audit Team

Lead Auditor	XXXXXXX	**Hours on site**	12	**Hours off site**	10

Other Auditors	XXXXXXX	**Total hours on site**	12	**Total hours off site**	6
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXXXX			**Hours**	3

Sample Totals

Total audit hours on site	24	Total audit hours off site	19	Total audit hours	43

Number of residents interviewed	7	Number of staff interviewed	12	Number of managers interviewed	2
Number of residents' records reviewed	7	Number of staff records reviewed	8	Total number of managers (headcount)	2
Number of medication records reviewed	20	Total number of staff (headcount)	28	Number of relatives interviewed	1
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	

Declaration

I, XXXXXXXX, Managing Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA has finished editing the document.	Yes

Dated Monday, 21 July 2014

Executive Summary of Audit

General Overview

Aspen Rest Home provides residential care for up to 54 residents and occupancy on the first day of the audit was 38. The service provider is certified to provide rest home level care. The facility is currently operated by Oceania Care Company Limited. This provisional audit is undertaken to establish the extent to which the existing provider conforms to the requirements of the Health and Disability Services Standards and the district health board (DHB) funding contract prior to a change in ownership. This audit also establishes how well prepared the prospective provider is to provide a health and disability service. A representative for the prospective provider, Aspen Lifecare Limited, was interviewed during this audit. Residents and family members interviewed provide positive feedback on the care provided.

There are three areas identified during this audit that require improvement that relate to: development and review of corrective action plans to address shortfalls identified in service delivery; documenting progress towards meeting the resident's needs in their care plans; and repairs and maintenance to the building and furniture.

Outcome 1.1: Consumer Rights

The facility ensures information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is accessible and is brought to the attention of residents' and their families on admission to the facility. Residents and family members interviewed confirmed that their rights are met at all times during service delivery; that staff are respectful of their needs; communication is appropriate; and they have a clear understanding of their rights and the facility's processes if these are not met.

During interview residents and family confirm that consent forms are provided to them prior to admission to ensure they have time for consultation and that they are fully informed. They also confirm that time is provided if discussions and explanation is required.

The business and care manager is responsible for the management of complaints and a complaints register is maintained. The residents can use the complaints forms, raise issues at the residents' meetings, or they can raise complaints directly with the business and care manager, the clinical leader, the registered nurse, or with any member of staff.

Outcome 1.2: Organisational Management

Oceania Care Company Limited is the current governing body and is responsible for the service provided at Aspen Rest Home. Planning documents reviewed include a vision statement, values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Aspen Rest Home including regular monthly reporting by the business and care manager to the Oceania support office. A business plan for the existing provider and a transition plan for the prospective provider are reviewed. The prospective provider's representative advised there will be a three month transition period during which time the existing policies and procedures and quality and risk management systems will be replaced with systems the prospective provider is using in their other facilities.

The facility is currently being managed by a suitably qualified and experienced temporary business and care manager who is a registered nurse with aged care experience. The business and care manager is supported by a clinical leader who is a registered nurse and who is responsible for oversight of clinical care provided. The clinical leader is supported by another registered nurse who works three days a week.

Aspen Lifecare Limited is proposing to purchase the facility and assume responsibility for the provision of services from 15 September 2014. Aspen Lifecare Limited has engaged a management company to manage the service provided at Aspen Rest Home. A representative from the management company was interviewed and has been involved in the aged care sector for the last 10 years in various roles. One of the directors for Aspen Lifecare Limited is also a director for the management company and this director has extensive experience in owning and managing aged care facilities. An organisational structure for the prospective provider was reviewed and demonstrates linkages between the two companies.

There is a documented internal audit programme available although improvements are required to the consistency with which corrective action plans to address all identified shortfalls are developed, implemented, monitored and signed off as being completed. Adverse events are documented on accident/incident forms and an electronic database.

There are policies and procedures on human resources management and the validation of current annual practicing certificates for personnel who require them to practise is occurring. In-service education is provided for staff at least monthly and staff are supported to complete the New Zealand Qualifications Authority Unit Standards to obtain a Certificate in Residential Care. A review of staff records provides evidence that human resource processes are being followed, orientations are being completed and individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. The minimum number of staff is provided during the night shift and consists of two health care assistants. The business and care manager and the clinical leader are on call after hours. Care staff interviewed report there is adequate staff available and that they are able to get through their work.

Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

Outcome 1.3: Continuum of Service Delivery

Aspen Rest Home has a documented entry criteria which is communicated to residents, family and referral agencies.

Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input, provided within stated timeframes and coordinated to promote continuity of service delivery.

Staff training records detail appropriate qualifications and/or experience and staff interviewed confirm they are trained and in their view competent to perform expected tasks.

Residents and family interviewed confirm their input into assessments, care planning and evaluation. Residents interviewed confirm that interventions noted in their care plans are consistent with meeting their needs.

A sampling of residents' clinical files validates service delivery to residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. Where progress is different from expected, the service responds by initiating changes to the care plan. There is one area requiring improvement that relates to the comprehensiveness of evaluation of care plans.

Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on one-on-one basis.

The medication systems evidence compliance with respective legislation, regulations and guidelines. Policies and procedures clearly detail service provider's responsibilities. Staff responsible for medicine management have attended medication in-service education and have current medication competencies. Appropriate systems are documented and implemented for residents who self- administer medicines.

Aspen rest home has a central kitchen and on site staff that provide the food service. Kitchen staff have completed food safety training. The menu has been reviewed by a dietitian. Residents' dietary needs are identified, documented and reviewed on a regular basis. There was positive feedback from residents about the food service.

Outcome 1.4: Safe and Appropriate Environment

Improvements were identified to several areas of the facility as the physical environment looks tired and several areas are identified as requiring maintenance. Some of the areas identified as requiring improvement include but are not limited to the furniture in the residents' bedrooms and chairs in the lounge which are damaged; the carpet is badly stained in several areas; six bedrooms on the middle level have been decommissioned as they have water damage; and external decking and paths have areas of moss and lichen.

All bedrooms provide single accommodation, have wash hand basins and are of varying sizes. There is an adequate number of toilet and shower facilities available throughout the facility. The main dining room and lounge area have ocean views. .An external area is available for sitting and shading is provided in external areas. An appropriate call bell system is available and security systems are in place.

Outcome 2: Restraint Minimisation and Safe Practice

There are no restraint or enablers used by residents at the facility on audit days.

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are least restrictive.

The service has processes in place at both governance and facility level for determining restraint approval and restraint processes.

Staff interviews and staff records evidence current training and restraint competency assessments.

Outcome 3: Infection Prevention and Control

There are infection prevention and control (IC) policies and procedures for the prevention and minimisation of infection and cross infection, and contain all requirements in the standard and guide staff in all areas of infection control practice.

New employees are provided with training in infection control practices and there is on-going education available for all staff.

Infection control is a standard agenda item at the facility meetings. Staff interviewed are familiar with infection control measures at the facility.

Surveillance for residents who develop infection is occurring and this is collated monthly and reported to Oceania head office.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	42	0	2	1	0	0
Criteria	0	90	0	2	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	5
Criteria	0	0	0	0	0	0	0	8

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	(i)Review of internal audits indicates that corrective action plans are not being consistently documented to address all areas identified as requiring improvement, (ii) The name / designation of the person/s responsible for implementation of the corrective action/s and the timeframe/s are not being consistently documented in internal audits, (iii) Evidence of monitoring and sign off of corrective action plans in internal audits and resident infection logs is not consistently documented.	Provide documented evidence that: (i) corrective action plans are being developed, implemented, monitored and signed off as having been completed that addresses all areas identified as requiring improvement, (ii) the name / designation of the person/s responsible for the corrective action plan/s is documented along with timeframes for the corrective actions, (iii) resident infection logs are being monitored and signed off for each episode of infection.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	The person centred care plan evaluations do not always evaluate all resident needs and the degree of achievement towards meeting the needs is not always recorded.	Provide evidence of the care plan evaluations recording all resident needs and documenting the degree of achievement toward meeting their needs.	90
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	Several areas of the facility have been identified as needing repairs / maintenance and / or replacing: (i) a large ceiling panel (the inspection panel) outside room 39 is damaged and needs replacing, (ii) the furniture in the lounge and several of the bedrooms is worn out, damaged, looking tired and needs replacing, (iii) the carpet is badly stained in some areas, (iv) six bedrooms on level 1 cannot be used due to water damage to carpets and / or ceilings, (v) there is moss / lichen on the external wooden decking and concrete paths, (vi) the external landings / fire exits off the main dining room and the lounge are potentially hazardous as the railing is approximately one metre high and there is a drop off of three levels to the ground	Provide confirmation that the repairs and maintenance issues identified have been addressed and that the building, fixtures and fittings are being maintained to an adequate standard.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				at the end off the dining room, (vii) the bench top in the large sluice room is painted and the paint is chipped in several areas, (viii) the lining in the shower room opposite room 26 is lifting, (ix) the walk in freezer in the kitchen has an unsealed wooden floor.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Staff receive training in the Code of Health and Disability Services Consumers' Rights' (the Code of Rights) at least annually and staff education records are sighted. Care staff are observed interacting respectfully and communicating appropriately with residents. Staff encourage residents to make choices demonstrating their knowledge of residents' rights.

Residents (seven rest home) and family member (one rest home) are able to verify that services are provided with dignity and respect at all times, privacy is maintained, and individual needs and rights are upheld. These findings are also confirmed during review of the resident and family survey that was completed in March 2014. The collated results for the 2014 survey indicate respondents are either 'very satisfied' or 'satisfied' with this aspect of service delivery.

Interviews with staff (the temporary business and care manager, one registered nurse, five health care assistants covering all three shifts, one diversional therapist and a physiotherapist) demonstrate an understanding of resident rights. Education records reviewed indicate that staff attend training in resident rights as part of their orientation as well as part of the ongoing education programme. This education was last provided in May 2014 and prior to this was provided in February 2014.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

One of the directors for the management company who will be overseeing the services provided is also a director Aspen Lifecare Limited (the prospective provider) has over 15 years' experience in aged care ownership, governance and management and has a thorough knowledge of the consumer rights they must adhere to. The compliance manager from the management company, who is experienced in the aged care sector, is interviewed and demonstrates a thorough knowledge and understanding of the consumer rights they must adhere to.

The Code of Rights and information on the advocacy service are displayed and are available at the facility and in the pre-admission enquiry and information packs provided on admission to the facility.

Residents (seven) and family member (one) interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to the resident's admission. The pre-admission enquiry and admission packs are reviewed and contains, but is not limited to, information on the Code, advocacy and complaints processes. Residents and family interviewed confirm explanations regarding their rights occur on admission and at any time that they may have a query.

The families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and seven admission agreements are reviewed as part of the review of resident's files and all are found to contain this level of information.

Residents interviewed confirm they have access to an advocate and one may be appointed if needed. Residents' meetings are held monthly and review of these meeting minutes indicates residents are aware of their rights. Resident / family satisfaction survey completed in March 2014 indicates residents and family are aware of their rights.

The district health board contract requirements are met.

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

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Attainment and Risk: FA

Evidence:

Residents are observed being treated with respect by staff during this audit and these findings are confirmed during interviews of residents and family member and during review of resident and family satisfaction survey completed in 2014.

Staff receive training on abuse / neglect and the last education session for staff was provided in November 2013. Staff are observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Care staff demonstrate an awareness of residents' rights and the maintenance of professional boundaries.

Activities in the community are encouraged and several residents attend community events independently. Where a resident wishes to continue with their hobbies or self-cares this is encouraged. Church services are held on site as part of the activities programme.

Values, beliefs and cultural aspects of care are recorded in residents' clinical files reviewed (seven rest home).

The district health board contract requirements are met.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)
The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)
Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)
Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: FA

Evidence:

The organisation has a Māori Health Plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. The Māori Health Plan describes that the holistic view of Māori health is to be incorporated into the delivery of services (whanau, Hinengaro, Tinana and Wairau).

There are currently no residents in the facility that identify as Māori. A cultural assessment is completed as part of the person centred care plan for all residents and is reviewed on the seven resident's files reviewed.

Access to Māori support and advocacy services is available if required via an Iwi group and from the local district health board. Family are able to be involved in the care of their family members.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education was last provided in March 2014.

The district health board contract requirements are met.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)
Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)
The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)
The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA

Evidence:

Documentation reviewed during this audit provides evidence that appropriate culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Documentation reviewed lists the details on how to access appropriate expertise - for example cultural specialists, and interpreters.

Residents' files reviewed demonstrate that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whanau contact details. All residents have a cultural assessment completed as part of the care planning process.

Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. These findings are supported during review of the resident/relative satisfaction survey completed in March 2014. Church services are held on site weekly as part of the activities programme and some residents go out to attend church services with the support of family and friends.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.

The district health board contract requirements are met.

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

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and a code of conduct that includes house rules. These documents also address any conflict of interest issues including the accepting of gifts and personal transactions with residents and are reviewed. Expected staff practice is also outlined in job descriptions and employment contracts, which are reviewed on eight staff files.

A review of the accident/incident reporting system, complaints register and interview of the temporary business and care manager indicates there have been no allegations made against staff alleging unacceptable behaviour.

Residents and family interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to.

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

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: FA

Evidence:

Systems are in place to ensure staff receive a range of opportunities which promote good practice within the facility. Documentation reviewed provides evidence that policies and procedures are based on evidence-based rationales.

Education is provided by specialist educators as part of the in-service education programme and this is confirmed during review of education records and interview of the temporary business and care manager, the Oceania clinical and quality manager and the registered nurses who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. The temporary business and care manager and the registered nurse advise the district health board (DHB) specialist nurses provide education and support for the clinical staff as needed. The clinical leader is absent during this audit.

Staff interviewed confirm understanding of professional boundaries and practice.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families and are reviewed. Residents' files reviewed (seven rest home) provide evidence that communication with family members is being documented in residents' records. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, on family communication sheets, and in the individual resident's files.

Residents and family interviewed confirm that staff communicate very well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care.

The temporary business and care manager advises access to interpreter services is available if required via the district health board, staff members, the local community, family members and interpreter services if required. They also advise there are currently no residents who require interpreter services.

The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Seven admission agreements are reviewed and this is clearly communicated in each agreement.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: FA

Evidence:

Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The temporary business and care manager and the registered nurse (RN) report informed consent is discussed and is recorded at the time the resident is admitted to the facility.

Residents/family are provided with various consent forms on admission for completion as appropriate and are reviewed on seven resident's files. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these are reviewed on resident's files.

Staff interviewed (five health care assistants, one registered nurse (RN) and the temporary business and care manager) demonstrate a good understanding of informed consent processes.

Residents (seven rest home) and family (one rest home) interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.

Residents' files reviewed demonstrate written and verbal discussions on informed consent have occurred and all residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme includes education on the Code of Rights and was last provided in May 2014.

The district health board contract requirements are met.

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

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Attainment and Risk: FA

Evidence:

There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates and these are reviewed.

Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they attended education on the Code of Right, advocacy, and complaint management as part of the in-service education programme. This was confirmed during review of staff education records.

An independent advocate from a church group visits the facility twice a month and provides advocacy support and pastoral care for residents.

Residents and family interviewed confirm that advocacy support is available to them if required, and that information on how to access the Health and Disability Advocate is included in the information package they receive on admission. Visual inspection provides evidence the nationwide advocate details are displayed along with advocacy information brochures. An admission / pre-admission enquiry pack is reviewed and provides evidence advocacy, complaints and Code of Rights information is included.

The district health board contract requirements are met

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

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Attainment and Risk: FA

Evidence:

There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service (e.g. visitors are required to sign in and out via registers). The activities programme includes access to community groups and there are systems in place to ensure residents remain aware of current affairs, including reading of the newspaper each day.

Residents and family members interviewed confirm they can have access to visitors of their choice, and confirm they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a mobility van is available to take residents on community visits. Some residents go out independently on a regular basis.

Residents' files reviewed demonstrate that activity plans identify support/interest groups. Progress notes and care plan content includes regular outings and appointments (records sighted).

The district health board contract requirements are met.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The temporary business and care manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes one complaint for 2014 and three for 2013 and the complaints register is reviewed.

The temporary business and care manager advises there have been no complaint investigations by the Ministry of Health, District Health Board, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. There has been one complaint made to the Health and Disability Commissioner in March 2013 that the Health and Disability Commissioner referred to the facility for investigation and reporting back to the Health and Disability Commissioner. Documentation reviewed indicates this complaint was closed off in July 2013 by the Health and Disability Commissioner.

Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents (seven rest home) and family (one rest home) interviewed demonstrate an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues they have during these meetings and this is confirmed during interview of residents and review of meeting minutes.

A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of quality/ staff meeting minutes and the temporary business and care manger's monthly reports provides evidence of reporting of complaints to the governing body and staff. Care staff interviewed confirm this information is reported to them via their staff meetings and that graphs of this data is displayed on the noticeboard in the staff room.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Oceania Care Company Limited (Oceania) is the current service provider and governing body. Aspen Lifecare Limited is proposing to purchase the facility and assume responsibility for the provision of services from 15 September 2014. Aspen Lifecare Limited has engaged a management company to manage the service provided at Aspen Rest Home (Aspen). A representative from the management company is interviewed and has been involved in the aged care sector for the last 10 years in various management roles. One of the directors for Aspen Lifecare Limited is also a director and general manager for the management company (HIL Management Services) has been involved in aged care ownership, governance and management for the last 15 years. An organisational structure for the prospective provider is reviewed and demonstrates linkages between the two companies as well as the structure for Aspen Rest Home.

The existing provider and prospective provider advise they have had preliminary discussions with the district health board (DHB) portfolio manager concerning transfer of the aged related residential care (ARC) contract to the prospective purchaser.

The facility is currently being managed by a temporary business and care manager (BCM) who is a suitably qualified and experienced registered nurse with aged care experience. The temporary BCM has a short term contract that commenced on 01 April 2014 and is due to finish on 16 August 2014. An Oceania clinical and quality manager, who was acting as the facility manager from 01 January 2014 to 01 April 2014, is interviewed and they advise that if the temporary BCM is unable to extend their contract beyond 16 August 2014 that they will assume responsibility for management of the facility until the prospective provider is able to recruit and appoint another facility manager.

The temporary BCM is supported by a clinical leader (CL) who is a registered nurse and who is responsible for oversight of clinical care provided. The CL is supported by another registered nurse (RN) who works three days a week.

The prospective provider advises that with the exception of recruiting and appointing a new facility manager they are not proposing to change any of the key personnel and staffing levels. The prospective purchaser advises the organisational structure will be reviewed over time and any necessary adjustments will be made as required.

Transition plans for the prospective provider and the existing provider are reviewed and includes a lists of tasks to be undertaken with responsibilities and timeframes identified. The prospective provider's representative advises there will be a three month transition period during which time the existing Oceania policies and procedures and quality and risk management systems will be replaced with systems the prospective provider are using in their other facilities.

The Oceania documented scope, direction, goals and vision are reviewed along with a written quality and risk management plan/policy identifying Oceania's quality goals, objectives, and scope of service delivery and includes statements about quality activities and review processes. A 'Clinical Risk Management Policy' and a 'Clinical Risk Management Plan' are reviewed along with documented values, mission statement and philosophy, which are displayed at the main entrance. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

Systems are in place for monitoring the service provided at Aspen including regular monthly reporting by the temporary BCM to Oceania support office via the Oceania intranet. Reporting includes reporting on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators and is sighted during this audit. The monthly business status reports are sighted and these reports are provided to the Oceania executive team and link to the organisations and facility's business plan.
Aspen is certified to provide rest home level care and have contracts with the district health board (DHB) to provide aged related residential care (rest home) and with the primary health organisation (PHO) to provide overnight care services for one to two days for residents with an acute illness needing additional support. On day one of this audit there are 38 residents assessed as requiring rest home level care.

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:

Finding:

Corrective Action:

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

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

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA

Evidence:

There are appropriate systems in place to ensure the day-to-day operations of the service continues should the temporary BCM and/or the CL be absent. The CL was absent during this audit due to illness and the registered nurse filled in for the CL. At present the CL fills in for the temporary BCM with support from an Oceania clinical and quality manager. The clinical and quality manager is interviewed and advises they were acting as the facility manager for the first four months of 2014 after the last facility manager left. They also advise they will assume this role again if the temporary BCM can not extend their current contract beyond 16 August 2014. Additional support and assistance is currently provided by other personnel from Oceania support office as required.

The prospective provider advises they will recruit and appoint a new facility manager, that there will be no changes to key personnel and that they will ensure plans for managing the service when rostered staff are absent will be maintained.

Services provided meet the specific needs of the resident group within the facility. Job descriptions and interviews of thetemporary BCM and CL confirms their responsibility and authority for their roles.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The prospective provider's representative advises there will be a three month transition period during which time the Oceania policies, procedures and quality and risk management systems that are currently being used at Aspen will be replaced with policies, procedures and quality and risk management systems the prospective provider is using in their other facilities.

The Oceania 'Quality Improvement Policy', 'Clinical Risk Management Policy' and a '2014 Quality Audit Schedule' are currently being used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme in place, risks are identified and there is a hazard register. Clinical indicators are documented on an electronic database that is able to be reviewed by personnel from Oceania Support Office. The prospective provider's representative advises that for the three months following Aspen Lifecare Limited assuming responsibility for the provision of service at Aspen that Oceania will provide them with quality improvement data and clinical indicators that has been entered on to their intranet.

Relevant standards and legislative requirements are identified and are included in the Oceania policies and procedures manuals. Policies and procedures reflect current accepted good practice. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff report copies of policies are available in the care station and that they are advised of updated policies via the

staff/quality meetings. Care staff also advise copies of updated policies are available for them to review in the staff room and evidence of this is sighted during this audit. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery

Internal audit schedules and completed audits for 2014 are reviewed during this audit. Improvements are required with corrective action plans to address shortfalls identified during internal audits (see criterion 1.2.3.8). The resident / relative satisfaction survey was completed in March 2014 and the collated results indicate that although residents are 'satisfied' or 'very satisfied' with the service provided, there are a few areas requiring improvement that residents have provided comment on. However, there is no corrective action plan documented to address these improvements (see criterion 1.2.3.8)

Clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. Review of the quality improvement data provides evidence the data is being collected, collated, evaluated and analysed to identify trends and that this data is being reported to staff and to the governing body. Quality / staff, health and safety / infection control and resident meetings are held monthly and minutes are reviewed. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Staff report during interviews that copies of meeting minutes and graphs of clinical indicators are available for them to review in the staff room. This is confirmed during visual observations during this audit.

The health and safety manual documents health and safety management systems including a health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements, and an emergency plan. Risks are identified and there is a hazard register which is reviewed that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Meeting minutes are reviewed and provide evidence of discussion and reporting on accident/ incidents; hazards; staff wellness programme, health and safety objectives and maintenance. Oceania holds Workplace Safety Management Practices accreditation at tertiary level for ACC workplace safety and this expires on 31st March 2015.

Chemical Safety data sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and are reviewed: all biomedical equipment has appropriate performance verified stickers in place.

Not all of the district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Various meeting minutes are reviewed and include corrective action plans to address any issues identified. The meeting minutes also identify responsibilities and timeframes for implementation and review. Adverse event forms also include preventative actions and corrective actions.

Finding:

(i)Review of internal audits indicates that corrective action plans are not being consistently documented to address all areas identified as requiring improvement, (ii) The name / designation of the person/s responsible for implementation of the corrective action/s and the timeframe/s are not being consistently documented in internal audits, (iii) Evidence of monitoring and sign off of corrective action plans in internal audits and resident infection logs is not consistently documented.

Corrective Action:

Provide documented evidence that: (i) corrective action plans are being developed, implemented, monitored and signed off as having been completed that addresses all areas identified as requiring improvement, (ii) the name / designation of the person/s responsible for the corrective action plan/s is documented along with timeframes for the corrective actions, (iii) resident infection logs are being monitored and signed off for each episode of infection.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The prospective provider, the existing provider and the temporary BCM advise during interview that they are not aware of any legislative compliance issues that could affect the service.
There is an adverse event reporting system in place. All accident/incidents are recorded on an 'Incident/Accident Reporting Form'. The temporary BCM also enters these accidents and incidents on the Oceania intranet as part of the reporting of monthly clinical indicators. Incidents recorded include but are not limited to incidents relating to absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse. An 'Incident/Accident' internal audit was last conduced in April 2014.

The prospective provider's representative advises there will be a three month transition period during which time the Oceania quality and risk management systems, including adverse event reporting, will be replaced with quality and risk management systems the prospective provider is using in their other facilities.

Resident files reviewed provide evidence that incident accident forms are completed as well as general observations being recorded for residents following falls. 'Neurological Observation Chart' and 'Fall – Post Assessment Form' are also completed for residents who have falls.

Communication with families following adverse events, or any change in resident's condition is evidenced in the residents' files reviewed. Staff education on communication and documentation was held in June 2014 as part of a core education half day session. During interviews staff demonstrate an awareness of the adverse event process.

Staff are made aware of their essential notification responsibilities through their job descriptions, Oceania policies and procedures and professional codes of conduct.

The district health board contract requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The temporary BCM is responsible for oversight of the in-service education programme at Aspen. The BCM advises that education inservice education is provided at least monthly as well as via four hourly core education training days. The temporary BCM advises an annual education plan is developed that is based on the Oceania education plan. Staff are also supported to complete a New Zealand Qualifications Authority Unit Standards Certificate in Residential Care. Staff are also required to attend the compulsory Oceania education sessions each year to progress through the Oceania career pathway programme. In-service education plans, staff competency registers and staff education records are maintained and are reviewed for 2013 and 2014.

The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority and are reviewed on staff files (eight) along with employment agreements, criminal vetting, completed orientations and competency assessments. Individual records of education are maintained for each staff member.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, dietitian, pharmacist, physiotherapist and general practitioners (GPs) is occurring. An appraisal schedule is in place and current staff appraisals sighted on staff files reviewed.

Five of five health care assistants (HCAs) interviewed working all three shifts and one RN confirms they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

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:

Finding:

Corrective Action:

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

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)
The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)
New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The prospective provider is interviewed and reports that initially they are not proposing to make any changes to the exisiting roster and staffing levels. The prospective provider states during interview they will be implementing a new policy on the staffing rationale that is based on 'SNZ:HB 8163:2005 Indicators for Safe aged-care and dementia-care for Consumers'.

The exisiting documented rationale ('Interim Staffing Policy') for determining staffing levels and skill mixes in order to provide safe service delivery is based on best practice. The rosters for the current service provider are reviewed and the minimum cover is provided between 11pm and 7am and consists of of two health care assistants (HCAs) plus the temporary BCM and the CL share the after hours on call. The roster is reviewed and indicates who the on-call person is. Registered nurse cover is provided Monday to Friday and occasionally at weekends by the registered nurse. A roster for the week 14 July 2014 to 20 July 2014 indicates that RN cover is provided Monday to Sunday inclusive. This CL usually works Monday, Tuesday, Thursday and Friday and the second RN works Wednesday, Thursday and Friday as well as some weekend days. The temporary BCM, who is also an RN, works Monday to Friday inclusive.

Care staff interviewed report that there is generally enough staff on duty and they are able to get through the work allocated to them. Residents interviewed report there is enough staff on duty to provide them with adequate care.

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: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA

Evidence:

Resident information is entered in an accurate and timely manner into a register (electronic) that is appropriate to the service and is in line with legislative requirements. Interview with the administrator confirms the resident details are entered into an electronic record on the day of admission.

Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed. Resident files reviewed provide evidence that an entry into the resident's clinical record is made on each shift and entries are clear, dated and signed.

A visual inspection of the facility provides evidence that residents' information is stored in staff areas and is held securely and is not on public display. Clinical notes are current and are accessible to all clinical staff. The resident's NHI number, name, and date of birth are used as the unique identifier.

Administration staff and clinical staff interviewed confirm they know how to maintain confidentiality of resident information. Historical records are held securely on site and are accessible.

The district health board contract requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Attainment and Risk: FA

Evidence:

Documented systems and processes are implemented to ensure resident's entry into the service has been facilitated in a competent, equitable, timely and respectful manner. Policies and procedures for entry criteria, assessment and entry screening are recorded and implemented. The service's vision and mission statements and values are recorded, displayed at the facility and communicated to residents, family, relevant agencies and staff.

The admission agreement defines scope of service and includes all the contractual requirements, sighted. All seven residents' admission agreements sampled evidence residents' and facility sign off. The business and care manager interview confirms access and entry processes are followed. This facility operates 24/7.

The service provides information to potential referral sources. Aspen rest home resident information booklet is sighted and contains all relevant information for the resident and family. Residents' files sampled demonstrate all needs assessments are completed for appropriate levels of care.

One of one family interview confirms the admission process was conducted by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted. Seven of seven resident interviews confirm their input into the admission process.

The district health board contract requirements are met.

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

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Attainment and Risk: FA

Evidence:

Systems to decline resident entry to the service are documented. The scope of the service provided by the organization is identified and communicated to all concerned. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the management. The resident will be declined entry if not within the scope of the service or if a bed is not available at the time and referred back to the NASC service.

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

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In all seven of seven resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with resident and/or family input and the service is coordinated to promote continuity of service delivery. Six of six clinical staff (one registered nurse and five health care assistants) interviews confirm residents and/or family members are involved in all stages of service provision.

Seven of seven resident interviews confirm their input into service delivery planning, care evaluations and multidisciplinary reviews, except one resident who has been admitted recently and multidisciplinary reviews have not been required, as yet. Seven of seven residents' files sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member, meet appropriate timeframes and demonstrate team approach into reviews and evaluations. Family communication sheets are maintained, sighted in all seven residents' files reviewed.

Documented handovers between shifts were sighted and the auditor evidenced verbal briefing from am to pm shift. GP interview was not able to be conducted.

Staff competency assessments are current and the staff competency register records competencies for all clinical staff in restraint, staff who administer medicines have current medication competencies and insulin administration, nebuliser and oxygen competencies. RNs also complete wound competencies and all clinical staff are educated in and complete hoist competencies.

The district health board contract requirements are met.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Attainment and Risk: FA

Evidence:

Residents' needs, outcomes and goals are identified via the assessment process and are recorded in a timely manner. The organisation has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. Policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.

Residents' files sampled evidence residents' discharge/transfer information from DHB are available, where appropriate. The facility has appropriate resources and equipment. The RN interview confirms that assessments are conducted in a safe and appropriate setting including visits from the doctor.

Seven of seven resident interviews confirm their involvement in their assessments, care planning, review, treatment and evaluations of care.

Seven of seven residents' files evidence risk assessments on admission are conducted and recorded on care plans. Initial care plans are recorded on admission and the long term care plan is recorded within the required timeframe and evaluated at six monthly intervals or when resident's condition alters.

The district health board contract requirements are met.

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

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Attainment and Risk: FA

Evidence:

All seven residents' files sampled evidence residents' care plans are individualised and up-to-date. The long-term and short-term goals are identified by the residents and service providers and reviewed at regular intervals, at least six monthly or as needs change. Residents have input into their care planning and review, confirmed at seven resident interviews. Six of six clinical staff interviews confirm that care plans are accurate and up to date.

All residents' files sampled evidence the clinical care/treatment/support or interventions that are to be provided by the staff is current, the risk assessment findings are recorded on the care plans and there is evidence of discussions and sign off by residents and family members. The facility ensures access to regular GP care, sighted in all residents' files on GP progress notes.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)
Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)
Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

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

Attainment and Risk: FA

Evidence:

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. All seven residents' files sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled. GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement. All seven residents interviewed and one of one family interview confirm their current care and treatments they are receiving meet their needs. Family communication sheets record family communications, sighted in all seven residents' files sampled

The district health board contract 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:

Resident, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.

The activities monthly calendar is sighted and evidences activities are provided Monday to Friday by activities staff and weekend activities include music on Saturday mornings and church services on Sunday mornings.

Residents' monthly meeting minutes evidence standard agenda and discussion in relation to administration, care services, housekeeping, health and safety, maintenance, food, activities programme, and other business - sighted minutes from meetings in 2014. Residents' meeting was conducted on second day of audit and evidences discussion according to the agenda and inclusion of infection control matters.

Seven of seven residents' files sampled demonstrate the individual activities plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being. Residents' activities assessments were sighted in all seven residents' files sampled.

Activities audit was conducted in November 2013 with 100% compliance. Interview with the diversional therapist confirms the activities programme meets the needs of the service group and the service has appropriate equipment.

Interview with the physiotherapist confirms staff notify them in timely manner of any residents requiring mobility assessments.

Seven of seven residents interviews confirm their past activities are considered and their enjoyment of the activities they choose to participate in. Activities attendance records are maintained and were sighted.

Resident satisfaction survey was conducted in March 2014, (refer to criterion 1.2.3.8).

The district health board contract 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: PA Moderate

Evidence:

Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. All seven residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Evaluation are conducted by the RNs with input from the resident, family, care staff, activities coordinator and GPs. Family are notified of any changes in resident's condition, evidenced in all seven residents' files sampled.

Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. Residents' files evidence referral letters to specialists and other health professional. Multidisciplinary reviews are current.

There is an area requiring improvement around evaluations recording the degree of achievement to the interventions provided and the progress made towards achieving resident's desired outcomes.

The district health board contract requirements are not fully 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: PA Moderate

Evidence:

Care plan evaluations are conducted by the RNs, are within stated timeframes and reviewed more frequently if a resident's condition changes. There is evidence of the resident, family, care staff, activities coordinator and GPs involvement in multidisciplinary reviews.

Person centred care plan evaluation forms evidence incomplete evaluation in two of seven files reviewed. The two incomplete evaluations do not record evaluation of challenging behaviour even though this has been identified on the residents' care plans. All seven evaluation forms reviewed do not always record the degree of achievement towards meeting the residents' needs.

Finding:

The person centred care plan evaluations do not always evaluate all resident needs and the degree of achievement towards meeting the needs is not always recorded.

Corrective Action:

Provide evidence of the care plan evaluations recording all resident needs and documenting the degree of achievement toward meeting their needs.

Timeframe (days): 90 *(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 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Attainment and Risk: FA

Evidence:

Service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services. Residents' files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required.

Residents' files sampled evidence family communication sheets document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented.

The district health board contract reuirements are met.

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

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

Resident files sampled evidence appropriate communication between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. The resident transfer forms contains all relevant information. Resident person centred care plan is sent with the resident upon transfer, confirmed at RN interview. Sighted the use of the Bay of Plenty district health board (DHB) transfer yellow envelope to hospital form from a residential care that includes all relevant forms on transfer. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files where appropriate.

The district health board contract requirement is met.

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

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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)F

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:

Visual inspection of the medication area in the facility, evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. There is one controlled drug storage in the facility and this is secure. The controlled drug register is maintained and evidences weekly checks and six monthly physical stock takes of controlled drugs by pharmacist are noted on the register. Medication fridge temperatures are monitored, sighted.

Residents' medicines charts list all medications a resident is taking (including name, dose, frequency and route to be given). Medication round was observed and there is evidence staff are signing off, as the dose is administered.

All staff authorised to administer medicines have current competencies, sighted in staff files sampled and on the staff competency register. There are two RNs and 13 health care assistants who administer medicines and have current competencies, Staff education in medicine management was conducted in May 2014 and attended by 11 staff.

Twenty medicine charts were sampled. All 20 medicine charts demonstrate residents' photo identification, medicine charts are is legible, as required medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs.

There is one resident at the facility that self-administers medicines. There is recorded evidence of the resident's three monthly competency assessments, residents signing sheets are maintained and the medicines are safely stored. Interview with the resident who self-administers medicines was conducted and evidences the resident is competent and aware of the responsibilities with self-administration of medicines.

Medication management audit was conducted in January 2014 with corrective actions addressed.

The district health board contract 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Food services policies and procedures are appropriate to the service setting with a new seasonal four weekly menu being introduced six monthly. The menu is developed by a dietitian and was last reviewed in March 2014.There are documented protocols for management of residents with unexplained weight loss or gain, including referral to a dietitian and speech language therapist as required.

Resident's individual dietary needs are identified, documented and reviewed on a regular basis as part of the care plan review. Kitchen staff are informed if resident's dietary requirements change, confirmed at interview with kitchen manager. Copies of dietary profiles reviewed in the kitchen and in residents' files.

Residents' files sampled demonstrate monthly monitoring of individual resident's weight. Resident's nutritional needs and interventions are identified and documented on the care plan. Residents interviewed were satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided. Food temperatures are recorded, sighted. Fridge and freezer temperatures are recorded, sighted

Visual inspection of the kitchen evidences the walk in freezer has an unsealed wooded floor (refer to criterion 1.4.2.1).

Kitchen services audit was conducted in April 2014 with corrective actions addressed.

Food safety was part of a staff core study day in June 2014 and attended by 16 staff.

The district health board contract 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:

Finding:

Corrective Action:

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

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)
All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA

Evidence:

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and are accessible for staff. A hazard register is sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided in February 2014. This finding is confirmed during interviews of domestic staff and review of staff education records.

Monthly visits are made by the chemical supplier representative who reviews kitchen, cleaning and laundry processes and their reports are reviewed.

Sluice facilities are available throughout the facility for the disposal of waste and hazardous substances. A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and is being used by staff. For example, goggles, gloves, aprons and masks are viewed in the sluice rooms, laundry and cleaners' room.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.

The district health board contract requirements are met.

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

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Improvements are required to management of the environment as the facility is looking tired and in need of refurbishment and several areas are identified as requiring maintenance and or replacement (see criterion 1.4.2.1). The prospective provider advises during interview they have no plans to make any structural changes to the environment.

A person is employed for 40 hours a week in a dual role of kitchen hand (32 hours) and maintenance person (seven hours) and is interviewed during this audit. The maintenance person is also responsible for maintenance of the lawns and another person is employed to maintain the gardens. During interview the maintenance person confirms there is a maintenance programme in place and maintenance documentation is reviewed. There is an enclosed external area with seating and shade as well as a raised garden.

Planned and reactive maintenance systems are in place and are reviewed during this audit along with current calibration / performance verified stickers on medical equipment and electrical testing and tagging labels. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 26 February 2015.

A visual inspection of the facility provides evidence of safe storage of medical equipment although storage space is limited. Corridors are of various widths and allow residents to pass each other safely; safety rails are secure and are appropriately located.

Staff report they receive education in the safe use of medical equipment by suitably qualified personnel. Care staff interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

Residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

Not all of 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: PA Low

Evidence:

Visual inspection of the facility indicates the facility is on three levels. The upper most level (level) has 48 single bedrooms and all residents are currently located in this area. The middle level (level 1) has six single bedrooms and residents were relocated from this area at the end of June 2014 as a result of water damage to the bedrooms.

The lower level (the basement) has an activities area with a bowling table in one large room. There is lift access between all three levels.

Level 2 main dining area and main lounge reviewed and have a fire exit at each end that leads to an external landing at each end. The end of the dining room is three levels above the ground and there is a direct drop to the ground. The exit off the lounge provides access to the roof on the next level down. Both exits have a railing that is approximately one metre high.

Report dated 9 June 2014 for medical equipment calibration is reviewed and indicates that any items of equipment that failed the calibration test have been removed from service. Medical equipment viewed has current calibration stickers in place. Electrical equipment reviewed has evidence of current testing and tagging.

During interview staff report they believe the facility has not been maintained and new furniture purchased as the building has been for sale for some time.

Finding:

Several areas of the facility have been identified as needing repairs / maintenance and / or replacing: (i) a large ceiling panel (the inspection panel) outside room 39 is damaged and needs replacing, (ii) the furniture in the lounge and several of the bedrooms is worn out, damaged, looking tired and needs replacing, (iii) the carpet is badly stained in some areas, (iv) six bedrooms on level 1 cannot be used due to water damage to carpets and / or ceilings, (v) there is moss / lichen on the external wooden decking and concrete paths, (vi) the external landings / fire exits off the main dining room and the lounge are potentially hazardous as the railing is approximately one metre high and there is a drop off of three levels to the ground at the end off the dining room, (vii) the bench top in the large sluice room is painted and the paint is chipped in several areas, (viii) the lining in the shower room opposite room 26 is lifting, (ix) the walk in freezer in the kitchen has an unsealed wooden floor.

Corrective Action:

Provide confirmation that the repairs and maintenance issues identified have been addressed and that the building, fixtures and fittings are being maintained to an adequate standard.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

All bedrooms provide single accommodation and have wash hand basins. There is an adequate number of toilet and shower facilities available throughout the facility. One of the bedrooms has full ensuite facilities.

Visual inspection provides evidence that toilet; shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).

Toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and wash basin facilities that meet specifications for people with disabilities that are large enough for manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

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

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA

Evidence:

Visual inspection provides evidence that the bedrooms allow for access for mobility aids. The bedrooms are of varying sizes and allow residents and staff to move around within the room safely and adequate personal space is provided. This finding was confirmed during interviews of staff and residents. All of the bedroom doors have locks on them that staff advise are not able to be locked. Staff obtained a key which fitted the locks to demonstrate the locks have been deactivated and are not able to be locked.

Resident's bedrooms are personalised to varying degrees.

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

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Visual inspection provides evidence that adequate access is provided to the lounge and dining room. Residents are observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA

Evidence:

Cleaning policy and procedures and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons. All laundry is washed on site and there is good dirty / clean flow. Laundry personnel interviewed describe the management of laundry including transportation, sorting, storage, laundering, and return to residents.

Visual Inspection provides evidence that cleaning and laundry processes are implemented. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and monthly visits from the chemical company representative. Completed audits for the laundry and cleaning are reviewed. Cleaning staff are interviewed and they describe the management of the cleaning processes including the use of personal protective equipment.

Visual inspection of the facility provides evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets are available; appropriate facilities exist for the disposal of soiled water/waste; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.

Residents interviewed state they are satisfied with the cleaning and laundry service. This finding is confirmed during review of completed family and resident satisfaction surveys.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification are sighted There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.

A New Zealand Fire Service (NZFS) letter dated 30 October 1997 is sighted advising the fire evacuation scheme is approved. The last trial evacuation was held on 17 April 2014 and there was a false alarm in March 2014. Fire and emergency education was last provided in April 2014.

All duty leaders, registered nurses, administration staff, diversional therapist, drivers of the van and most health care assistants have current first aid certificates. There are at least two designated staff members on each shift with appropriate first aid training.

Staff interviews and review of files provides evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records sampled provides evidence of current training regarding fire, emergency and security education.

Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.

A visual inspection of the facility provides evidence that: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations.
A visual inspection of the facility provides evidence that emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply

(potable/drinkable supply and non-potable/non-drinkable supply), blankets, and cell phones are available.

There is a call system in place that is used by the resident or staff members to summon assistance if required. This system is old but residents interviewed confirm they have a call bell system in place which is accessible and staff respond to it in a timely manner. Call bells are accessible / within reach and are available in resident areas.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)
The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection provides evidence that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Residents interviewed confirm the facilities are maintained at an appropriate temperature.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)
All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)
Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The service has processes in place at both governance and facility level for determining restraint approval and processes. Residents' files sampled evidence residents/family input into care assessment, care planning and evaluation of care.

There is a documented process for the approval of specific restraint processes at the policy/procedure level. The role of the restraint co-ordinator is delegated to a suitably skilled and experienced service provider, the clinical leader /RN. Position description sighted.

Six of six clinical staff interviews evidence awareness of the restraint co-ordinator's responsibilities, restraint policy/procedures and alternatives to restraint. There are policies relating to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement.

The orientation/induction programme includes overview of restraint policies and procedures. Staff education programme includes on-going restraint training. Challenging behaviour and de-escalation training was presented in March 2014. Restraint processes were part of a core study day in June 2014.

Managing challenging behaviour audit was conducted in March 2014 with corrective actions addressed. Restraint competencies sighted on staff register and individual staff files. There are no residents who use restraint or enablers at the facility on audit days.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control (IC) policy meets the needs of the organisation and provides information and resources to inform the service providers on infection prevention and control. The IC policy and procedure manual was reviewed in February 2014. The delegation of infection control matters throughout the organization is clearly documented along with the IC co-ordinator job description. Clinical staff interviewed confirm the infection control management systems provide them with adequate guidance

There is documented evidence the governing body receives regular reports on infection related issues by regular reporting systems. Visual inspection evidences staff provide additional infection management precautions. The Oceania IC programme is reviewed by the Oceania IC committee with input from Oceania managers and IC nurses. Oceania IC committee comprises of the General Manager and Clinical and Quality staff. Sighted Aspen Rest Home infection control programme objectives for 2014.

The business and care manager discussed infection control issues at the residents' meeting, evidenced on audit day.

The district health board contract requirements are met.

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

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control programme meets the needs of the organisation and provides information and resources to inform and guide staff. The IC co-ordinator / RN is the clinical leader with relevant skills, expertise and resources necessary to achieve the requirements of this standard. The IC co-ordinator has access to health care professionals regarding infection control matters. There is access to relevant and current information which is appropriate to the size and complexity of the organization, including: IC manuals, internet, access to experts (DHB and Lab), and on-going in-service education. Sighted a register of resident and staff flu vaccinations.

The district health board contract requirements are met.

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

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA

Evidence:

Policies and procedures on the prevention and control of infection include written material that is relevant to the organisation and reflects current accepted good practice and relevant legislative requirements. Policies and procedures are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel. Oceania IC policies and procedures are developed and reviewed regularly in consultation and input from Oceania staff, as well as external experts. IC policies and procedures identify links to other documentation in the organisation such as health & safety, quality and risk. Clinical staff interviewed confirm infection control policies and procedures are freely available for them.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Service provider's documentation evidences that infection control education is provided to all staff, as part of their initial orientation and as part of the on-going in-service education programme.

Staff interviewed advice that clinical staff identify situations where IC education is required for a resident such as; hand hygiene, cough etiquette, multi-resistant micro-organisms. This was evidenced as part of the residents' meeting discussion with rise of respiratory infections in the facility.

Staff on going education in IC was provided January 2014. All education sessions have evidence of staff attendance and content of the presentations.

Hand washing competencies for all staff are conducted, sighted register. The IC co-ordinator education records evidence of attendance at the IC prevention and control nurses college NZNO conference in November 2013 and Oceania training in IC in October 2013. The RN also attended the Oceania IC training in October 2013, sighted in staff files and confirmed at RN interview. External training in skin infection was attended by the RNs in June 2014.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The IC programme / policy details surveillance processes, including the surveillance objectives, priorities and methods at a level of detail relevant to the service setting and its complexity. 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.

Infection control monthly data includes type of infection, lab results, sensitivities, antibiotics prescribed, dose, duration, intervention, review and outcome. Numbers of infections are collated at the end of each month and reported as a clinical indicator to Oceania head office and at facility's meetings. Care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, and daily handovers. Evidenced at the handover conducted on first day of audit.

Infection control audit was conducted in July 2014 with corrective actions addressed.

Management and clinical staff interviews confirm there have been no outbreaks at the facility.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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