# Oceania Care Company Limited - Eden Lifestyle Care & Village

## Current Status: 21 July 2014

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

## General overview

Oceania Care Company Limited (Oceania) Eden Lifestyle Care and Village can provide care for up to 70 residents. During the audit there were 28 residents living at the facility including 16 residents requiring rest home level of care and 12 residents at hospital level of care. The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and regional and executive management.

Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys with benchmarking completed with other Oceania facilities.

The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads and acuity with rosters indicating on each shift and residents are supported by health care assistants with residents and family stating that they receive a high standard of support.

There are no improvements required.

## Audit Summary as at 21 July 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 21 July 2014

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

### Organisational Management as at 21 July 2014

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 21 July 2014

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

### Safe and Appropriate Environment as at 21 July 2014

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

### Restraint Minimisation and Safe Practice as at 21 July 2014

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 21 July 2014

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

## Audit Results as at 21 July 2014

### Consumer Rights

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

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent policy and processes are implemented by the service, meeting contractual requirements.

Staff ensure residents are informed and have choices related to the care they receive. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

### Organisational Management

Oceania has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. Quality and risk performance is reported across the facility meetings and monitored by the organisation's management team through the business status reports.

Benchmarking reports are produced that include incidents/accidents, infections and complaints. These are used to provide comparisons with other facilities.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation/induction programme that provides new staff with relevant information for safe work practice and an ongoing training programme.

Staff identify that staffing levels are adequate and interviews with residents and relatives demonstrated that they have adequate access to staff to support residents when needed.

There is a business and care manager appointed who is supported by a clinical manager.

### Continuum of Service Delivery

Entry to service delivery is by a pre-admission process through the needs assessment co-ordination service. Residents declined entry are entered into the system with the reason given for the decline of service. The resident records reviewed evidenced the provider had implemented systems to assess plan and evaluate the care needs of the residents. The residents’ needs, outcomes and/or goals are identified and reviewed with resident/family input.

The general practitioner was interviewed by phone during the audit.

The service is co-ordinated to promote team work and continuity of care. Service delivery and interventions are clearly documented. Evaluations occur where progress is different from expected, the service responds by initiating changes to the person centre care plans.

The activities programme was effectively co-ordinated and implemented in a planned and organised manner. External activities are encouraged into the community and family participation is welcomed.

Medicine management processes are implemented with the Robotic dispensing system being used. Staff responsible for medicine management have current medication competency assessments, and receive ongoing education for medication management. The medication system evidences full compliance with respective legislation, regulations and guidelines. Three monthly medication reviews are completed by the GP.

The food service is very unique as Café style and fine dining is available. Residents have choices and family are welcome. Meals are also served in the residents` own rooms if this option is more practical or the choice of the individual resident. The service is managed by an experienced Chef and is assisted by two junior Chefs and other appropriate staff. The kitchen staff are informed by the nursing staff if any residents required special dietary needs. Resident individual needs are reviewed on a regular basis. The menu plans are reviewed by the company dietitian annually.

### Safe and Appropriate Environment

All building and plant comply to legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. There are adequate numbers of toilets and showers across the facility with access to a hand basin and paper towels. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Activities can occur in any of the lounges and furniture is arranged to ensure residents are able to move freely and safely.

Laundry is outsourced and the managers and staff monitor cleaning to ensure that the facility is cleaned to a high standard.

Essential emergency and security systems are in place with regular fire drills completed. There is a civil defence kit for the whole facility. Call bells are evident across the facility in resident’s rooms, lounge areas, and toilets/bathrooms and all are monitored to ensure that they are functioning at all times.

### Restraint Minimisation and Safe Practice

The restraint programme is developed and implemented and clearly defines the use of enablers and restraints. The service actively minimises restraint and the use of enablers. The general practitioner and the clinical nurse manager (restraint co-ordinator) are actively involved should a resident require a form of restraint for safety purposes and to maintain independence. The education schedule and restraint policy reviewed identifies on-going education relevant to the service setting and includes restraint minimisation, challenging behaviour and de-escalation techniques.

### Infection Prevention and Control

Infection control management systems are documented and implemented to minimise the risk of infection to residents, service providers and visitors. The infection prevention and control programme meets the needs of the service and provided information and resources to inform staff. The policies and procedures in place reflect current accepted good practice and legislative requirements. These effectively reflect the needs of the service and care setting and are readily available for staff to access. Relevant infection control education is provided to all staff and to the residents, family and visitors as required. Adequate resources are available throughout the facility and signage is apparent.

The type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Results of surveillance are reported to relevant personnel in a timely manner. The clinical nurse manager was the designated infection control co-ordinator.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Oceania Care Company Limited |
| **Certificate name:** | Oceania Care Company Limited - Eden Lifestyle Care & Village |

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

|  |  |
| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Eden Lifestyle Care and Village |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 21 July 2014 | **End date:** | 22 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:** | 28 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX  | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 12 | **Total hours off site** | 8 |
| **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 | 6 | Number of staff interviewed | 9 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 37 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **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 Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Thursday, 31 July 2014

## **Executive Summary of Audit**

**General Overview**

Eden Lifestyle Care and Village (Oceania) can provide care for up to 70 residents. During the audit there were 28 residents living at the facility including 16 residents requiring rest home level of care and 12 residents at hospital level of care. The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and regional and executive management.

Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys with benchmarking completed with other Oceania facilities.

The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads and acuity with rosters indicating on each shift and residents are supported by health care assistants with residents and family stating that they receive a high standard of support.

There are no improvements required.

**Outcome 1.1: Consumer Rights**

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

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent policy and processes are implemented by the service, meeting contractual requirements.

Staff ensure residents are informed and have choices related to the care they receive. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

**Outcome 1.2: Organisational Management**

Oceania has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. Quality and risk performance is reported across the facility meetings and monitored by the organisation's management team through the business status reports.

Benchmarking reports are produced that include incidents/accidents, infections and complaints. These are used to provide comparisons with other facilities.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation/induction programme that provides new staff with relevant information for safe work practice and an ongoing training programme.

Staff identify that staffing levels are adequate and interviews with residents and relatives demonstrated that they have adequate access to staff to support residents when needed.

There is a business and care manager appointed who is supported by a clinical manager.

**Outcome 1.3: Continuum of Service Delivery**

Entry to service delivery is by a pre-admission process through the needs assessment co-ordination service. Residents declined entry are entered into the system with the reason given for the decline of service. The resident records reviewed evidenced the provider had implemented systems to assess plan and evaluate the care needs of the residents. The residents’ needs, outcomes and/or goals are identified and reviewed with resident/family input.

The general practitioner was interviewed by phone during the audit.

The service is co-ordinated to promote team work and continuity of care. Service delivery and interventions are clearly documented. Evaluations occur where progress is different from expected, the service responds by initiating changes to the person centre care plans.

The activities programme was effectively co-ordinated and implemented in a planned and organised manner. External activities are encouraged into the community and family participation is welcomed.

Medicine management processes are implemented with the Robotic dispensing system being used. Staff responsible for medicine management have current medication competency assessments, and receive ongoing education for medication management. The medication system evidences full compliance with respective legislation, regulations and guidelines. Three monthly medication reviews are completed by the GP.

The food service is very unique as Café style and fine dining is available. Residents have choices and family are welcome. Meals are also served in the residents` own rooms if this option is more practical or the choice of the individual resident. The service is managed by an experienced Chef and is assisted by two junior Chefs and other appropriate staff. The kitchen staff are informed by the nursing staff if any residents required special dietary needs. Resident individual needs are reviewed on a regular basis. The menu plans are reviewed by the company dietitian annually.

**Outcome 1.4: Safe and Appropriate Environment**

All building and plant comply to legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. There are adequate numbers of toilets and showers across the facility with access to a hand basin and paper towels. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Activities can occur in any of the lounges and furniture is arranged to ensure residents are able to move freely and safely.

Laundry is outsourced and the managers and staff monitor cleaning to ensure that the facility is cleaned to a high standard.

Essential emergency and security systems are in place with regular fire drills completed. There is a civil defence kit for the whole facility. Call bells are evident across the facility in resident’s rooms, lounge areas, and toilets/bathrooms and all are monitored to ensure that they are functioning at all times.

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

The restraint programme is developed and implemented and clearly defines the use of enablers and restraints. The service actively minimises restraint and the use of enablers. The general practitioner and the clinical nurse manager (restraint co-ordinator) are actively involved should a resident require a form of restraint for safety purposes and to maintain independence. The education schedule and restraint policy reviewed identifies on-going education relevant to the service setting and includes restraint minimisation, challenging behaviour and de-escalation techniques.

**Outcome 3: Infection Prevention and Control**

Infection control management systems are documented and implemented to minimise the risk of infection to residents, service providers and visitors. The infection prevention and control programme meets the needs of the service and provided information and resources to inform staff. The policies and procedures in place reflect current accepted good practice and legislative requirements. These effectively reflect the needs of the service and care setting and are readily available for staff to access. Relevant infection control education is provided to all staff and to the residents, family and visitors as required. Adequate resources are available throughout the facility and signage is apparent.

The type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Results of surveillance are reported to relevant personnel in a timely manner. The clinical nurse manager was the designated infection control co-ordinator.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 101 | 0 | 0 | 0 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

## **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 education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. The last training for staff has been in February and July 2014.

Interviews with the clinical manager, three of three health care assistants and two registered nurses confirm their understanding of the Code.

Examples are provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.

The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information.

The auditors noted respectful attitudes towards residents on the day of the audit.

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:**

The business and care manager, clinical manager or a registered nurse discusses the Code, including the complaints process with residents and their family on admission.

Discussions relating to the Code can also be held at the residents' meeting.

Residents and family interviews confirm their rights are being upheld by the service.

Information regarding the Health and Disability Advocacy Service is clearly displayed in the foyer of the facility.

Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the entrance to the service. If necessary, staff will read and explain information to residents as stated by the health care assistants and registered nurses interviewed.

Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.
Six of six residents (three rest home and three hospital) and three family members are able to describe their rights and advocacy services particularly in relation to the complaints process.

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:**

The service has a philosophy that promotes dignity and respect and quality of life.

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people’s beliefs and values with the registered nurses and clinical manager interviewed stating that the care plans are completed with the resident and family member (confirmed by residents and family interviewed).

Interventions to support these are identified and evaluated.

Residents are addressed by their preferred name and this is documented in eight of eight files reviewed.

A policy is available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality (sexuality and intimacy) in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour. Staff have received training around sexuality and intimacy last in September 2013 and in February 2014.

The service ensures that each resident has the right to privacy and dignity, which is recognised and respected. The residents’ own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room and there are areas in the facility which can be used for private meetings.

Three health care assistants interviewed report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirm the residents’ privacy is respected.

Health care assistants interviewed report that they encourage the residents' independence by encouraging them to be as active as possible. A physiotherapist is available one day a week with the ability to see residents if required during the week. Health care assistants assist residents with their activity programmes.

The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. They are committed to provide guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the organisation’s mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code.

Staff receive mandatory education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation. Staff interviewed are aware of the signs of abuse and neglect and they have received training around abuse and neglect last in June 2014.

Resident files reviewed (six including three rest home and three hospital) identifies that cultural and /or spiritual values, individual preferences are identified.

There are weekly church services, visits from a Catholic priest to take communion and a spirited conversation weekly.

There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.

There is a strong focus on the service on respecting dignity and independence.

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 service implements the Maori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan.

Links to local kaumatua Maori services are documented and include Ngati Whatua through the Orakei Marae. The site was blessed prior to opening with the kaumatua able to engage with the service at any point.

There are no Maori residents living at the facility during this full certification audit.

Staff interviewed report specific cultural needs are identified in the residents’ care plans. This was further evidenced in six of six resident files selected for review (three hospital and three rest home).

Staff are aware of the importance of whanau in the delivery of care for their Maori residents.

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:**

The service identifies each resident’s personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline. There is also a strong culture of choice with the resident determining when cares occur, times for meals, choices in meals, choices in activities etc.

Residents and family are involved in the assessment and the care planning processes as confirmed in interviews with residents and families. Information gathered during assessment includes the resident’s cultural values and beliefs. This information is used to develop a care plan and includes input from the resident and their family (confirmed by six residents.

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:**

The facility implements Oceania policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care.

Job descriptions include responsibilities of the position, ethics, advocacy and legal issues with a job description sighted in seven of seven staff files reviewed.

The orientation and employee agreement provided to staff on induction includes standards of conduct.

Interviews with staff including the business and care manager, regional clinical and quality manager, two activity coordinators, three health care assistants, two registered nurses and the clinical manager confirm their understanding of professional boundaries, including the boundaries of the health care assistants’ role and responsibilities.

District Health Board contract requirements are met.

##### **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:**

Eden Lifestyle Care and Village implements Oceania policies to guide practice. These policies align with the health and disability services standards and are reviewed annually. There is a quality framework that that supports an internal audit programme. Benchmarking occurs across all the Oceania facilities

There is a training programme and managers are encouraged to complete management training. There is a monthly regional management meeting.
Specialised training and related competencies are in place for the registered nursing staff.

Residents and families interviewed expressed a high level of satisfaction with the care delivered.

The general practitioner reports a high standard of care is provided at the service and the registered nurses demonstrate good clinical assessment skills.

Consultation is available through the organisation’s management team that includes registered nurse, dietician etc. A physiotherapist is available one day a week and is on site and can see residents at any time during the week.

The first resident came into the facility in October 2013. The key projects continue to the be following: a) implementing Oceania systems, b) implementing the model of care that is based on the premises of choice, hospitality, excellence of care that interconnects with the Connect model, c) embedding the hospitality ethic that permeates genuine family interaction with residents in their home, d) making the resident’s suite their home with staff as invited guests, e) implementing an activities model that is not demeaning, is resident driven and interactive, f) employing of staff with ‘kind hearts’.

The residents and family interviewed confirm that the model is in practice.

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:**

Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced in completed accident/incident forms.

Family contact is recorded in residents’ files – sighted in six files reviewed.
Interviews with three family members confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member.
Family interviewed confirm that they are invited to attend the monthly resident meetings.

Interpreter services are available when required from the District Health Board. One resident speaks XXXXXX and has flip charts to help staff interpret. The family providing interpreting services for the resident.

Staff also interpret on a day-to-day basis with staff identifying as having a range of ethnicities/language.

The information pack is available in large print and advised that this can be read to residents.

Staff have had training around communication in April 2014 and training around open disclosure last in June 2014.

Residents sign an admission agreement on entry to the service as sighted in the six resident files reviewed. This provides clear information around what it paid for by the service and what is paid for by the resident as ‘extra’ on top of care provided. All six are signed on the day of admission.

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:**

There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. The policy determines that staff ensure all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care. Residents are able to make their wishes, requirements and expectations known and to trust that these will be followed.

All resident files identified that informed consent is collected.

Interviews with health care assistants identify their understanding of informed consent processes. They described how informed consents are sought in the delivery of personal cares including daily choices and communication and this is confirmed by residents who identify that they are able to make choices.

The service information pack includes information regarding informed consent.

The registered nurse (RN) or by the clinical manager (CM) discuss informed consent processes with residents and their families/whānau during the admission process.

The advance directive and consent policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files note that all have appropriately signed advanced directives. All have been signed on the day of admission.

Discussion with family identifies that the service actively involves them in decisions that affect their relatives lives.

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:**

Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service.

Staff training on the role of advocacy services is included in training on The Code of Health and Disability Consumers’ Rights – last provided for staff in February 2014 and again as part of advocacy and open disclosure – last provided in July 2014.

Discussion with family and residents identifies that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.

The resident file includes information on residents family/whanau and chosen social networks with a communication sheet kept on the resident file and completed when family visit, ring etc.

Staff including the three health care assistants interviewed are aware of the right for advocacy and how to access and provide advocacy information to residents if needed.

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:**

The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings (earlier in winter to coincide with dusk) but visitors can arrange to visit after doors are locked.

Families interviewed confirm they can visit at any reasonable time and are always made to feel welcome.

Family were seen coming and going freely on the days of the audit.

Residents are encouraged to be involved in community activities and maintain family and friends networks. Links are also encouraged through church with some residents still engaged in community activities including attending their own church services.

Residents are included in outings with family members and are encouraged to bring family in to the restaurant and to the service to enjoy meals with them. A focus of the service has been to make the service and environment as welcoming as possible for family and the staff and business and care manager stating that furniture is often moved around to cater for activities that include family.

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 organisation’s complaints policy and procedures is in line with the Code and includes time frames for responding to a complaint. Complaint’s forms are available at the entrance.

A complaints register is in place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint’s folder.

While there are no complaints lodged for 2014 for residents in the rest home or hospital, there is one recorded from a resident in the village. A review of this complaint indicates that the complaint was investigated promptly with the issue resolved in a timely manner.

Six residents and three family members interviewed all state that they would feel comfortable complaining. One family member states that a complaint had been made and this has been addressed immediately. Another states that the family had made a complaint and this has been addressed. Both state that their complaints are more to do with the service adjusting to new roles involved in the setting up of the facility. The complaints are in the complaints register.

The business and care manager states that there have been no complaints with the Health and Disability Commissioner since the provisional audit or with other authorities.

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:**

Eden Lifestyle Care and Village is part of the Oceania group with the executive management team including the chief executive, general manager, regional manager, operations manager and clinical and quality managers providing support to the service.

Communication between the service and managers takes place on a monthly basis.

Oceania has a clear mission, values and goals. The vision is to be the provider of choice for senior New Zealanders of care and lifestyle options in a way that meets and exceeds the expectations of our residents, staff and stakeholders. The mission is ‘we provide excellent contemporary care that reflects our residents’ individuality and their right to choice, respect and dignity. We provide a positive and welcoming environment in which our residents are encouraged and supported to improve their quality of life’.

The facility can provide care for up to 70 residents (all bedrooms are large and are able to accommodate residents who require rest home or hospital level care). During the audit there are 28 residents living at the facility including 16 residents requiring rest home level of care and 12 residents requiring hospital level of care.

The business and care manager is responsible for the overall management of the facility. The business and care manager provided leadership in the development stage of the site development and has over 40 years’ experience as a registered nurse in diverse areas of inpatient and community services. The business and care manager has spent 10 years in aged care with Oceania and is resigning as of the 1 August 2014. Another business and care manager is appointed and is receiving a handover form the current business and care manager.

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:**

In the absence of the business and care manager, a clinical manager is in charge with support from the regional clinical and quality manager who has been in the role for 14 months and with Oceania for three years.

The current clinical manager has been employed since the service opened and has five years’ experience in aged care and three years’ experience in management roles.

The regional clinical and quality manager states that in the event of any changes in the management structure, there is always good support from the network of managers as part of the Oceania hierarchy.

The opening meeting of the audit was attended by the regional operations manager, the regional clinical and quality manager, senior clinical and quality manager, the business and care manager and the clinical manager.

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:** FA

**Evidence:**

Eden Lifestyle Care and Village uses the Oceania quality and risk management framework that is documented to guide practice.

The business plan is documented and reported on through the business status reports.

The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy at the nurses stations and in the business and care managers office. New and revised policies are presented to staff to read and staff sign to stay that they have read and understood – sighted and confirmed by the three health care assistants interviewed. On the meeting schedule there is a facility to call a meeting around new or revised policies if required.

Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed. The corrective action plans also include documentation of the meeting in which the issue was discussed. There is documentation that includes collection, collation, identifying trends and analysis of data.

Meeting minutes evidence communication with staff around all aspects of quality improvement and risk management with the following meetings held monthly: health and safety including infection control, quality, registered nurse, housekeeping, kitchen, maintenance, activities and two weekly head of department meetings. The meet schedule includes opportunities to add in meetings if these are required. There are also resident meetings (meeting minutes sighted for February and May 2014). All staff interviewed report they are kept informed of quality improvements and corrective action plans.

Results are benchmarked across all Oceania aged care facilities with a business status report completed by the business and care manager monthly (sighted). This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products.

There is an annual family and resident satisfaction survey with the questionnaires sent out in July 2014. There is a six week post entry satisfaction survey completed by each resident. Survey results indicate a high level of satisfaction with the service.

The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures, and a health and safety plan are in place for the service. There is a hazard management programme documented 2014 with a hazard register for each part of the service e.g. kitchen, office, care provision room. There is evidence of hazards identification forms completed when a hazard is identified and the hazard form updated. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.

The organisation holds a current ACC Work Safety and Management Practice tertiary level accreditation.

Health and safety is audited monthly.

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:** 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 1.2.3.9 (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 business and care manager is aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are no times since the last audit when authorities have had to be notified. There have been no outbreaks since the last audit.
The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the clinical manager, business and care manager and regional clinical and quality manager.

Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.

Ten incident reports were selected for review. Each incident report has a corresponding note in the progress notes to inform staff of the incident. There was evidence of open disclosure for each recorded event.

Information gathered is regularly shared at the monthly executive management and regional meetings with the business and care manager documenting incidents which are then graphed, trends analysed and benchmarking of data occurring.

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 registered nurses and the clinical manager hold current annual practising certificates. Visiting practitioner’s practising certificates include the general practitioner, podiatrist and physiotherapist.

Seven staff files randomly selected for audit include appointment documentation on file including signed contracts, job descriptions, reference checks and interviews. There is an appraisal process in place with all staff having a current performance appraisal. First aid and CPR certificates are held in the staff files.

Police checks are completed at the head office

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract.

Health care assistants are paired with a senior caregiver for shifts or until they demonstrate competency on a number of tasks including personal cares.

Annual medication competencies are completed for all registered nursing staff who administer medicines to residents. Other competencies are completed including hoist, oxygen use, hand washing, wound management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower.

The organisation has a mandatory education and training programme with sessions held weekly. Staff attendances are documented and there is evidence of good staff attendance.

The three health care assistants state that they value the training. Education and training hours exceed eight hours a year.

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 staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.

There are a total of 37 staff including a business and care manager, clinical manager, two activities coordinators with a third staff member transporting residents e.g. for outings, three chefs, two kitchen hands, four cleaners, five registered nurses and one casual, 12 health care assistants and other staff such as maintenance, concierge, administrators.

The rosters for an occupancy of 28 residents is as follows:
Two registered nurses in the morning and afternoon and one overnight.

There are five health care assistants in the morning (four full shift and one short shift), four in the afternoon (three full shift and one short shift to help with mealtime) and two health care assistants overnight.

The business and care manager confirms that staffing is changed as residents come into the facility noting that the service is not at full capacity.

Residents and families interviewed confirm staffing is adequate to meet the residents’ needs.

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:**

The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service.

There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.

Entries are legible, dates and signed by the relevant healthcare assistant, registered nurse or other staff member including designation.

Resident files are protected from unauthorised access by being locked away in an office. Informed consent is obtained from residents/family/whanau on admission to display photographs.

Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.
Individual resident files demonstrate service integration. This includes medical care interventions.

Medication charts are in a separate folder with medication and this is appropriate to the service.

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:**

Policy identifies entry processes which are communicated to residents, family/whanau and referral agencies. A care facility enquiry form is to be completed with each enquiry. The form utilised clearly details the potential residents’ details, care type being rest home or hospital level care, general comments and a check list of referral information. The business and care manager is responsible for managing all enquiries. An information pack is available and reviewed. A tour of the facility can be arranged for residents/family. This is a new facility and has only been open since October 2013. A show room is available. Currently because of the occupancy residents can have a choice of rooms available.

Six residents files reviewed consisting of (three rest home and three hospital residents), evidence that all residents have had their assessments by the needs assessment and service co-ordination assessors (NASC - ADHB) prior to admission. A copy of the NASC assessment or InterRAI assessment (International resident assessment instrument which is a standardised assessment tool) is retained in each individual resident’s file. The outcome of the assessments is documented as for rest home or hospital level of care. Sections of the clinical file are clearly documented in the front of each file to guide staff. The signed resident agreements are accessible and dates and signatures are able to be verified. The agreements are also kept in each residents’ file in the administration section.

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:**

The business and care manager at interview describes the processes undertaken should entry to this service be declined. This includes notification to appropriate persons and agencies. If a potential resident does not have the appropriate assessment for rest home or hospital level care, or is declined entry to the service, the admission form and notes record the communication with the referrer or the alternative service. The resident agreement has a statement that indicates when a resident is required to transfer if a higher level of care is required. Specialised dementia care is an example of this as the service is not able to accommodate a resident requiring this specialised care. The NASC service would be required to undertake another assessment or families guided to a more appropriate care facility if needed.

The district health board contract requirements are met.

##### **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:**

There are policies and procedures in place to identify how residents receive timely, competent and appropriate services to meet their needs as identified by the assessment processes in place for this service. The clinical nurse manager and two registered nurses interviewed identify that the comprehensive assessments are performed on admission prior to the development and implementation of the initial care plan. The initial care plan is completed with the resident and/or family input. The initial care plan is documented within twenty four hours of admission taking into consideration the NASC assessment. The long term care plan is developed within three weeks of admission ensuring the timeframes in the service agreement are effectively met.

The six resident files reviewed (three rest home and three hospital) have been reviewed six monthly or earlier if changes have occurred. One family member interviewed verified that input is sought when the care plan is reviewed. There are seven registered nurses employed inclusive of the clinical nurse manager. Each nurse is responsible for about three or four residents care plans ensuring these are current and up to date at all times. The healthcare assistants provide the majority of the personal cares for the residents. Three healthcare assistants interviewed confirm team work is encouraged and continuity of care is promoted. Handovers are provided by the registered nurses between all shifts and this was observed.

Each stage of service delivery is undertaken by qualified and suitably skilled staff. The annual practising certificates (APCs) for the seven registered nurses employed are available and sighted. Also the APCs of the pharmacist, general practitioner and podiatrist are available and a copy is retained by the clinical manager. A system is set up for reviewing these APCs annually. There is an appropriate education programme and spread sheet available for review which captures all education for each individual member of staff. The programme is colour coded to verify (red) – needs action taken, (blue) up to date and (green) needs monthly update. One GP at interview cares for all but one of the residents at this facility. The GP visits regularly and is on call seven days per week twenty four hours a day. They spoke highly of the senior staff and the effective communication between visits and with the pharmacy to meet the needs of the residents.

The six resident individual files (three rest home and three hospital) reviewed evidence the comprehensive assessment process, set goals for the resident that identifies the physical, psychological and cultural aspects for each resident. The services additional recognised assessment tools when residents are admitted or when reviewing the resident at six months or earlier if required.

The service is co-ordinated in a manner that promotes continuity in service delivery and promotes a team approach. This is clearly evident when interviewing clinical and non-clinical staff during this audit. A team approach and continuity of care is encouraged at every opportunity and this is verified in the six individual residents’ files reviewed (three rest home and three hospital). The GP interviewed reports that the registered nurses work collaboratively with the multidisciplinary team for the best outcomes for the residents.

The staffing is adequate and the rosters were discussed with the clinical manager. Additional staff can be arranged if needed. Staff will be increased as the numbers of residents increase in this new service. The needs of the residents` are currently being met.

The district health board contract requirements are met.

Tracer Methodology: Rest Home

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

Tracer Methodology: Hospital

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

##### **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:**

As well as the comprehensive assessment on admission the registered nurses also have available several recognised assessment tools to use for at risk residents for example falls risk, depression scales, pressure area risk, mini mental, nutritional assessments, cognitive status & function, continence and other tools as needed.

The needs, outcomes and goals of residents are identified during the pre-assessment NASC assessment and from the comprehensive assessment performed by a registered nurse on admission for each resident. Assessments are used as the basis for care planning. The six files reviewed (three rest home and three hospital) are clearly documented and easy to follow through. The assessments serve as the basis for the initial and short term care plans reviewed. This is evident in the two resident files reviewed. The one family interviewed state they are highly satisfied with the care their family member is receiving at this care facility. Five residents (three rest home and two hospital) report they receive care that meets their needs adequately.

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:**

Resident care planning is put in place from the findings of the assessment process. The initial person centred care plan is developed and implemented within twenty four hours of the resident’s admission. The six care plans reviewed have a standardised format that is individualised to the resident’s assessed needs. The files of the residents reviewed (three rest home and three hospital) have appropriate long term person centred care plans that clearly identifies the individual needs and care requirements, inclusive of specific plans to respond to decreasing falls, increasing mobility and decreasing weight. The six files reviewed demonstrate integration inclusive of input from care staff, activities, medical services and allied health services. The three healthcare assistants interviewed report they receive adequate information to assist the continuity of care. The handover observed is presented by the registered nurse and included updates on residents, planned outpatient appointments, diabetic monitoring and other significant information to share with staff.

The one family, five residents and the GP report a high level of satisfaction with the quality of care provided at Eden rest home and hospital.

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:**

Short term person centred care plans are used for problems that can be resolved within a relatively short time. The six person centred care plans reviewed record interventions that are consistent with the residents’ assessed needs and desired objectives/goals. Family are notified if there is any changes to the care plan and this is recorded in the care progress records. Observations on the day of the audit validated residents receiving care that is appropriate and consistent with the individual resident`s needs.

The five residents and one family interviewed report that the service meets the needs of the residents. The three healthcare assistants interviewed report that the person centred care plans are up to date and do reflect the individual resident’s needs and are able to be followed easily.

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:**

The individual activities assessments performed on all residents on admission provides the content for the activities programme. The programme developed and implemented ensures the strengths, skills and interests of residents are maintained. The activities co-ordinator is very experienced and is supported by an activities assistant. Both staff members are very passionate about their roles and each co-ordinator works full time (40 hours a week). A weekly programme is displayed but the actual programme is developed on a monthly basis. The programme includes outings in the community in the company van which accommodates nine residents and the driver. An informed consent form for transport is completed and a copy is filed in each residents file. The business and care manager has a system for verifying the current driver’s licences of staff.

The two activities co-ordinators have access to a computer for planning activities, and the weekly activities schedule is able to be printed out in colour. A large photo board is in a prominent position which displays some of the recent activities pursued by residents. One on one activities or ‘friendly visits’ are provided for those residents that cannot participate for one reason or another in the main activities programme. The activities co-ordinator maintains a record of each activity and a documented description of each activity provided. The recreation attendance sheet is colour coded and records electronically the resident`s participation or if declined, the type of activity enjoyed, individual or group activity. Six randomly selected residents files reviewed each had activities history and activities plans that are current and up to date. Activities are appropriate to their needs, age, culture and the setting of this service. The one family and five residents interviewed state they enjoy the programme on a daily basis. Family/whanau are able to participate anytime.

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:** FA

**Evidence:**

Policy identifies that the person centred care plans are evaluated if there is any change in the resident`s condition and reviewed every six months. Care plan review timeframes shown in policy range from weekly to six monthly, depending on the residents condition. Multidisciplinary input is considered for all residents for the six monthly reviews. Reviews occur earlier if there is a change in the resident`s status. Interventions are changed if required to ensure all needs and goals set can be effectively met. All evaluations are recorded, dated and signed by the registered nurse undertaking the review.

If a resident is not responding to the service interventions being delivered, or the health status changes, then this is discussed with their GP and the GP interviewed validated this information. Short term care plans are sighted for wound care, infections, changes in mobility and food and fluid intake, and/or skin care and pressure area risk. These processes are clearly documented on the short term person centred care plan, medical and nursing assessments and in the residents’; progress records. The resident/family/whanau communication and education is recorded in the progress records. If progress is different from expected the family/whanau are notified and a record is documented on the progress record.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.3.9: 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:**

There are processes in place should residents/family wish to access another health and disability service. The service commenced in October 2013 so this has not occurred in relation to a resident changing service providers. The GP interviewed reports that referrals to ADHB or outpatients services are responded to quite promptly. Copies of referral forms and/or evidence of residents attending other services is in the residents individual files reviewed. All correspondence is filed appropriately. Transportation can be arranged to take residents to an appointment if family/whanau are unable to take them.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

Transition, exit, discharge or transfer are all covered in policies and procedures. If a resident`s condition or health status changes the GP is notified by the clinical nurse manager and/or the registered nurse on duty. Should a resident require higher level of care or dementia care, a referral is sent to the NASC service ADHB for a re-assessment to be completed. When approved, assistance is provided in the event of this occurring, to find a more suitable alternative service provider. If a resident is to be transferred to ADHB Auckland Hospital as an acute admission the GP contacts the service required to arrange the admission. The nursing staff arrange the transportation and complete the resident transfer form and the transfer yellow envelope information required. The resident register is maintained and a record noted in the individual resident`s record of the transfer and/or admission.

The admission/discharge summary is fully completed when a resident is transferred to another service (eg, to another aged care facility) if this has been authorised and arranged by the NASC service or the geriatrician for older people’s health at Auckland Hospital. The admission information details are already completed in the yellow envelope of relevant clinical history and a full assessment of usual daily living abilities. The Person centred care plan is attached to the envelope which details the personal care and support required.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a detailed medicine management policy that is reflective of current safe practice guidelines. The policy identifies that staff who administer medicines must be competent. All registered nurses give out the medications at this facility. All have completed medication competencies and records are maintained. Procedures comply with legislative requirements. Medication reconciliation processes are clearly described. The medication system is the robotic system which is implemented for this service and this is being managed effectively by the clinical manager. The pharmacist and pharmacist technicians APCs are on record and all are valid.

There are two medication trollies one for each floor. The GP and the clinical manager interviewed report safe practice is identified and good communication exists between the pharmacist, the GP and the Clinical manager. The lunchtime medication round is observed. The registered nurse wears a blue apron to identify that the medication round is in progress. Two registered nurses check the one controlled drug together before administration. The registered nurses current APCs and training records are available and sighted.

The registered nurses order the medication. Twelve medication records are available and are randomly selected for review. There is evidence of the residents` medication being reviewed three monthly by the GP, dated and signed off appropriately. There is evidence of pharmacist input. A pharmacy stamp dated and signed is used on each record reviewed to verify that it has been checked prior to dispatch from the pharmacy. All sensitivities or allergies are documented on the medical records and on the medication record in red ink. There is currently no resident that is self-medicating. The registered nurses check all medication on arrival to this facility from the pharmacy. The twelve medication records reviewed have photo identification on the front record sheet and on the signing record. Staff signatures can be verified. The cupboard storing medication is well organised and shelves are labelled clearly. The two medication room fridges one on each floor are monitored and the temperatures recorded and sighted are within the recommended range for storing medication.

The controlled drugs are stored appropriately. A red signing record sheet is utilised to evidence controlled drugs used. The controlled drugs are checked out by two nurses and the weekly balance is checked weekly. Swipe card access is required to the medication rooms (2) one on each floor of this aged care facility.

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:**

There are nutritional and safe food and fluid management policies in place. They cover appropriately all aspects of this standard including additional or modified nutritional needs, weight loss management and gaining weight processes with dietitian input. The Oceania Company dietitian has reviewed the annual menu plans which are next due for review in August 2014. The menu is displayed daily. The residents have two options to have their meals in the main dining room or in their rooms. Special diets can be arranged.

On admission the registered nurse completes the nutritional status assessment tool for each resident and a copy is given to the Chef. Any likes or dislikes are considered for each individual resident. The dining room is very large and currently shared with residents from the lifestyle village. It is a café plated service. One area is designed as a café and residents can purchase food and drinks during the day or have time with family in the Café if able. The current system is working effectively but will have to be reviewed as the intake of residents` increases. A hot cabinet is available to transfer trays/meals to residents` rooms. The Chef is responsible for the temperature monitoring of the walk in chiller, freezer, under buffet cabinet, retail fridge and milk fridge on a daily basis. Records are maintained and reviewed.

The Chef is fully qualified and has two junior Chefs who work and cover the kitchen as well as a sandwich maker and kitchen hands. All staff are trained in food safety/food handling certificates. The Chef has worked at this facility since January 2014 and has worked the last 17 years in a variety of settings. The Chef spoke highly of the effective communication which occurs between clinical staff, the care and business manager and kitchen staff to ensure the needs of the residents are met. Special functions such as birthdays and anniversaries are celebrated. Cakes are prepared for birthdays. The Chef stated flexibility is considered with meal preparation and families are welcome.

Oceania cleaning schedules are well developed and implemented and closely adhered to by the staff in the kitchen. Any high cleaning is contracted to another service provider. The service has received excellent feedback from family members and a survey has recently been sent to residents and families. Information will be collated when returned to the business and care manager by the end of July 2014.

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:**

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation 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 accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

The provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by staff. During a tour of the facility protective clothing and equipment was observed in all high-risk areas.

Visual inspection of the facilities 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. Infection control policies state specific tasks and duties for which protective equipment is to be worn.

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:** FA

**Evidence:**

A current code of compliance is posted in a visible location at the entrance to the facility (expiry date 19 August 2014). There have been no building modifications since the last audit.

There is a planned maintenance schedule implemented.

The lounge areas are designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounges on the day of the audit.

The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats.

There is a test and tag programme two yearly and this is up to date with BV Medical checking clinical equipment.

Interviews with three health care assistants, two registered nurses and the clinical manager confirm there is adequate equipment.

There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required.

There are safe outside areas that is easy to access for residents and family members.

District Health Board contract requirements are met.

##### **Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)**

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**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:**

There are adequate numbers of accessible toilets/bathing facilities. This includes full ensuites, visitors, toilets and communal toilets conveniently located close to communal areas.

Communal toilet 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.

Six residents and three family members interviewed report that there are sufficient toilets and showers.

District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.

Equipment was sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff and the resident.

Rooms can be personalized with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own.

There is sufficient room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.

District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

The service has lounge/dining areas and each suite has a kitchenette. All areas are easily accessed by residents and staff.

Residents are able to access areas for privacy if required.

Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.

There is a specific area for the hairdresser, a shop and restaurant that includes a bar and café.

District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Laundry is subcontracted to a service and is independent to the service.

Residents and family members state that the laundry is well managed and they get back their clothes.

There are cleaners on site during the day seven days a week. The cleaners are observed to have the trolley in the room with them when cleaning and all had appropriately labelled containers. Ecolab products are used with training around use of products provided throughout the year.

Cleaning is monitored through the internal audit process with no issues identified in audits.

Chemicals and cleaning cupboards are locked.

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:**

An evacuation plan was approved by the New Zealand Fire Service on 16 August 2013. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly with the last drill conducted in October 2013 and March 2014. The orientation programme includes fire and security training. Staff confirm their awareness of emergency procedures.

There is always one staff member at least with a first aid certificate on duty – confirmed through review of the roster and confirmed by the business and care manager.

All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes.

A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ with two gas bottles. A port can be used to plug in a generator.

An electronic call bell system utilises a pager system. There are call bells in all residents’ rooms, residents’ toilets, and communal areas including the hallways, dining room and hairdressing space. Call bell audits are routinely completed and the last audit indicates that calls are answered in less than five minutes – confirmed by residents and family interviewed.

The doors are locked in the evenings doors can only be opened from the inside. Systems are in place to ensure the facility is secure and safe for the residents and staff. External lighting is adequate for safety and security with sensor lights on the outside of the building.

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 evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.

Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.

There are large windows into hallways and all rooms have sliding doors onto a deck.

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:**

Restraint minimisation and safe practice policies and procedures are clearly documented in the ‘Restraint Minimisation and Safe Practice Handbook & Policies’ manual reviewed March 2013 by Oceania Group. Policy provides clear definitions of what constitutes an enabler and/or restraint. Enablers are the use of equipment, devices or furniture, voluntarily used by the resident following appropriate assessment by the clinical nurse manager or a registered nurse, that limits normal freedom of movement, with the intent of promoting independence. The use of enablers shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting independence and safety.

There is one restraint in use for one hospital level resident. There are two bedside rail enablers in use at the time of the audit. Interviews with clinical staff confirm their knowledge and understanding related to restraint versus enablers and how they are effectively managed. Staff can verbalise the alternative methods put in place to keep the environment as restraint free as possible. Staff education covers restraint minimisation and de-escalation techniques, such as calming, re-direction, activities, ensuring regular toileting and understanding the `cue signs` of residents’ needs. All staff have received appropriate restraint education in 2014 and this training is recorded by the clinical manager and is evidenced in the six individual staff files reviewed.

The clinical manager interviewed is the restraint co-ordinator and stated that the service works at keeping the environment restraint free by talking to family/whanau and residents about the use of alternatives and the staff are able to explain the benefits of using restraint versus not using restraint if applicable.

There are appropriate policies and procedures in place to guide staff actions related to restraint and enabler use.

Oceania has a national restraint authority group which has at least an annual meeting and all restraint use is discussed for all facilities. The minutes dated 20 February 2014 are available for review. This service was operating at that stage but no residents were using restraint. The one resident using restraint commenced the use of a lap-belt 19 March 2014. The restraint approval group for Eden Rest Home and Hospital met last on the 8 March 2014. The clinical manager and the general practitioner is the approval group for this service reporting to the business and care manager. Both residents with enablers are able to make their own decisions and use bedrails for safety and to assist them to maintain independence when moving around their bed at night.

District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

#### Standard 2.2.1: Restraint approval and processes **(**HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

The restraint approval group for this service is the clinical nurse manager and the GP. However, the Oceania Company Clinical and Quality Team are responsible for approving any form or type of restraint practice or device. Terms of reference for the facility restraint minimisation team is clearly documented. This includes the types of restraint that may be used and under what circumstances they can be used. The organisation has a national restraint authority group that meets at least annually and minutes of the last meeting are available. This group reviews and ratifies the policies and procedures and evaluates the use of restraint and restraint philosophy/ethical considerations. The restraint approval includes the clinical nurse manager and the general practitioner for the resident involved. A job description is available. The clinical manager who is the restraint co-ordinator reports to the business and care manager and to the organisation`s national approval group.

The district health board requirements are met.

##### **Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)**

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 2.2.2: Assessment **(**HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a documented risk assessment framework to identify the risk factors and the need for restraint use. Restraint is only authorised following a comprehensive assessment of the individual by the restraint co-ordinator. A full assessment of the resident s required and review of previous clinical care. Identification of previous strategies attempted and determining the exact reason necessitating the need to consider the use of restraint. In addition, identifying the resident`s reaction to restraint intervention and consideration of residents wishes is taken into account. Any instructions in advance directives are also taken into consideration. The co-ordinator has to determine the desired outcome of the use of an approved restraint and the most suitable form for the individual resident which shall be the least invasive and least restrictive. Ongoing support and care is to be planned and provided and an appropriate plan of when to terminate restraint intervention needs to be documented. Family/whanau communication is of paramount importance to a successful outcome.

The district health board contract requirements are met.

##### **Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)**

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:
(a) Any risks related to the use of restraint;
(b) Any underlying causes for the relevant behaviour or condition if known;
(c) Existing advance directives the consumer may have made;
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
(f) Maintaining culturally safe practice;
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
(h) Possible alternative intervention/strategies.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 2.2.3: Safe Restraint Use **(**HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

All approved restraint is only used as a last resort for safety reasons. All residents using a form of restraint and enablers are entered into the restraint register which was reviewed. There are two enablers and one restraint used currently at this facility for resident safety. The resident using the lap belt (restraint) has not undergone a multidisciplinary review as this is not due to occur for another two months. The multidisciplinary reviews are completed every six months. Up until the present time the safety of the resident has not been compromised with the use of the restraint. There is a comprehensive decision process for the use of restraint.

The clinical manager is well qualified to perform the role of restraint co-ordinator. The job description for the restraint co-ordinator was reviewed as well as the restraint form utilised for this service. The registered nurse (RN) interviewed is responsible for the hospital level residents and undertakes the appropriate assessment and develops the individual restraint plan as guided by policy and the recommendations of the Oceania National Restraint Group. The RN documents how often the monitoring is to take place for the individual resident.

The restraint team meeting minutes dated the 8 March 2014 are available for review. The restraint information is loaded into the intranet (electronic system) by the clinical manager and the register sighted is well maintained.

The district health board contract requirements are met.

##### **Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)**

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:
(a) Only as a last resort to maintain the safety of consumers, service providers or others;
(b) Following appropriate planning and preparation;
(c) By the most appropriate health professional;
(d) When the environment is appropriate and safe for successful initiation;
(e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)**

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:
(a) Details of the reasons for initiating the restraint, including the desired outcome;
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
(c) Details of any advocacy/support offered, provided or facilitated;
(d) The outcome of the restraint;
(e) Any injury to any person as a result of the use of restraint;
(f) Observations and monitoring of the consumer during the restraint;
(g) Comments resulting from the evaluation of the restraint.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)**

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 2.2.4: Evaluation **(**HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint episodes are evaluated at a rate required relevant to the identified risk. The restraint evaluation form developed and implemented is used to review the restraint event to ensure that the restraint implementation meets Oceania Care Company’s requirements for the use of restraint. The restraint co-ordinator is responsible for completing the evaluation. The restraint register is then updated to provide an auditable trail of the restraint event. Any data collected is reported by the restraint co-ordinator to the business and care manager and to the Oceania Restraint National Group as applicable using the reporting tool reviewed. Evaluation of support needs and or advocacy is evaluated. Also whether the restraint used was the least restrictive option and that appropriate monitoring and observation occurred to maintain safety at all times. Once the evaluation of restraint is completed the care plan is updated to guide staff and further education provided to staff when and if required. The one resident using a form of restraint has not been reviewed except on a daily basis as the restraint has only been in use since March 2014.

The district health board contract requirements are met.

##### **Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)**

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:
(a) Future options to avoid the use of restraint;
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
(d) Whether the desired outcome was achieved;
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;
(f) The duration of the restraint episode and whether this was for the least amount of time required;
(g) The impact the restraint had on the consumer;
(h) Whether appropriate advocacy/support was provided or facilitated;
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
(j) Whether the service's policies and procedures were followed;
(k) Any suggested changes or additions required to the restraint education for service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)**

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 2.2.5: Restraint Monitoring and Quality Review **(**HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

The monitoring and evaluation of the restraint minimisation programme operates at two levels. The facility’s restraint co-ordinator the clinical nurse manager is responsible for oversight and the ongoing operation of the programme for this service including monitoring the programme’s level of success. The Oceania Policy is also to be followed. The Oceania Regional Clinical and Quality Team is responsible for the evaluation of the effectiveness of all programmes including measuring relevant clinical key performance indicators. The ‘restraint use audit outcome form’ is used for each individual resident if a restraint is used.

Any key problems identified and/or area of focus is acknowledged and quality improvement action required is detailed with time frames and the person who will be responsible. Any issues would be discussed at the health and safety/quality meetings. Any identified risks or triggers identified will be clearly documented to guide staff and for care planning purposes. Collaborative care planning with family/whanau involvement is paramount.

The district health board contract requirements are met.

##### **Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)**

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:
(a) The extent of restraint use and any trends;
(b) The organisation's progress in reducing restraint;
(c) Adverse outcomes;
(d) Service provider compliance with policies and procedures;
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
(g) Whether changes to policy, procedures, or guidelines are required; and
(h) Whether there are additional education or training needs or changes required to existing education.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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 manual identifies clear lines of accountability for infection control matters which includes senior management and staff. The aim of the infection prevention and control policy and procedures is to ensure the provision of service which is consistently safe for residents, staff and visitors to the facility. There is an infection prevention and control manual on both floors of the facility for staff to access. The manuals have been reviewed February 2014. The infection prevention and control programme is to be reviewed annually. An interview with the clinical manager provided insight into infection control management for this service. The clinical manager is the infection control co-ordinator. The infection control co-ordinator role is clearly defined and is clearly documented with functional relationship and who to be accountable to. Key responsibilities are documented to guide staff. The clinical manager is supported by eight registered nurses two of whom were available for interview. The two registered nurses at interview report they fully understand the objectives of the programme and the importance of reporting all incidences of infection. The infection prevention and control programme is linked to the quality and risk management programme. There is a flow chart available to guide staff on the infection control responsibilities.

The Oceania Group clinical quality managers (six in this group) developed the Pandemic Management Plan now implemented for this service. The service opened in October 2013. Strategies are in place for outbreak management. There have been no outbreaks since the service commenced. A process is identified in policy for the prevention of exposing providers, residents and visitors from infection. Staff and visitors suffering from an infectious disease are advised not to enter the facility and notices are evident at the reception. Staff interviewed two registered nurses and three health care assistants, two activities co-ordinators, one chef understand about staff illness and when not to come to work and when to return to work. Sanitising and gel dispensers are observed throughout the facility and there is adequate hand-washing facilities for staff and residents.

There is a criteria for sending specimens to the laboratory and if a resident is asymptomatic a specimen is not sent. Infections are reported on as to being rest home or hospital level care and reported in the type of infections for example; wounds, chest infections (upper respiratory and lower respiratory) urinary tract infections. Due to this service being relatively new and residents being offered with consent the influenza vaccinations and pneumococcal virus this has decreased the incidence this winter so far of the number of residents presenting with respiratory infections.

Education has been provided to staff on transmission precautions during the orientation/induction to this service and infection control education is ongoing as evidenced on the training programme reviewed. Any laboratory results for residents are reviewed by the general practitioner (GP) who signs them off and a copy is retained in the individual resident`s file. Once established benchmarking will occur with other like services in this organisation (Oceania).

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:**

Policies and procedures identify how the service implements the infection control programme which covers all requirements of the Health and Disability Service Standards. The infection prevention and control committee comprises of a team of staff from all areas of the service. The clinical manager is very experienced and has the expertise and resources available to meet the standard requirements. The clinical manager is well supported by the registered nurses. The committee comprises of the infection control co-ordinator, the business and care manager, administrator, maintenance representative, kitchen manager, housekeeper, activities co-ordinator, one registered nurse and one health care assistant. Staff at interview have a good understanding about the infection control programme implemented in all areas of service delivery.

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:**

There is a full set of up to date policies and procedures on both floors of this facility related to all required aspects of infection control as appropriate for this aged care setting. The policies and procedures and guidelines reviewed reflect current good practice and meet relevant legislative requirements. There are clear guidelines on how to manage infections and outbreaks effectively.

Observations at the onsite audit identify implementation of infection prevention and control procedures. Staff interviewed and observed during the audit demonstrate safe and appropriate infection prevention and control practices.

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:**

Infection control education is provided in the orientation programme and is part of the training programme for 2014. The training programme reviewed evidences infection prevention and control education which covers wound care, foot-care, food safety, bladder/bowel care and resources available such as personal protective equipment for all service areas. This was clearly visible on the tour of the facility and resources are accessible for staff. Full training on infection control is provided to all staff employed prior to the facility admitting residents and education has been ongoing. The clinical manager maintains records of all staff attending these sessions in the training records provided and a record is kept in each staff members’ individual record sighted. The two registered nurses at interview have a good knowledge of infection control procedures such as management of urinary tract infections, wound-care management and specimens to the laboratory. Any education provided to residents is recorded on the resident’s individual file.

An infection control kit is readily available with resources such as gloves, masks, infection control signage, and disposable gowns. This is available for any infection outbreaks. The kit is checked monthly and stored in the treatment room on the ground floor.

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:**

Policy identifies that surveillance data is used to identify trends and corrective planning is put in place as appropriate. The organisation has a system in place to ensure infection control is managed by a suitably qualified person who is a registered nurse and the clinical manager for this service. Expert advice can be sought from the general practitioner (who was interviewed and reports to be pleased to participate or provide advice whenever needed), and /or the laboratory microbiologist or the nurse practitioner from ADHB if required. The contracted pharmacist to the service is also available for consultation.

The clinical manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (eg, facility acquired infections) are documented to guide staff. Information is collated on a monthly basis for respiratory, urinary tract infections, gastrointestinal, influenza, skin and soft tissue (fungal and/or cellulitis), multi-resistant infections (MRI), diarrhoea, eye, nasal infections. Surveillance is appropriate for the size and nature of the services provided.

Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control co-ordinator. For the first 10 months since the service commenced infection control was incorporated in the quality improvement meetings held monthly. Currently the infection control committee has separate infection control meetings monthly to discuss data analysis, any issues arising, trends or findings. The minutes (sighted) are of the infection control meeting held 28 May 2014. Any outcomes are reported to the quality improvement meeting held three monthly. The infection prevention and control programme is closely linked to the health and safety programme and the quality and risk programme.

##### **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.)*