# Oceania Care Company Limited - Redwood Retirement Village

## Current Status: 4 August 2014

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

## General overview

This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standards and the District Health Board contract.

The Redwood Retirement Village provides care for up to 83 residents for rest home and hospital levels of care. At the time of the audit the occupancy was at 76 residents (27 hospital and 49 rest home). The facility is operated by Oceania Care Company Limited that provides corporate, financial, operational, administrational and clinical support to the facility.

An area identified requiring improvement at the last certification audit around self -administration of medicines was fully attained. There were areas identified at this surveillance audit that require improvement around complaints, corrective actions, informed consent, medication management systems.

## Audit Summary as at 4 August 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 4 August 2014

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

### Organisational Management as at 4 August 2014

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

### Continuum of Service Delivery as at 4 August 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 4 August 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 4 August 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 4 August 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. |

# 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 - Redwood Retirement Village |

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

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Redwood Retirement Village |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 4 August 2014 | **End date:** | 5 August 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:** | 76 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 4 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 2.5 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 10.5 | Total audit hours | 34.5 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 10 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 9 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 28 | Total number of staff (headcount) | 70 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, 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 | Yes |
| g) | Health Audit (NZ) Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health Audit (NZ) Limited has finished editing the document. | Yes |

Dated Monday, 11 August 2014

## **Executive Summary of Audit**

**General Overview**

This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standards and the District Health Board contract.

The Redwood Retirement Village provides care for up to 83 residents for rest home and hospital levels of care. At the time of the audit the occupancy was at 76 residents, (27 hospital and 49 rest home).The facility is operated by Oceania Care Company Limited, who provide corporate, financial, operational, administrational and clinical support to the facility.

An area identified requiring improvement at the last certification audit around self -administration of medicines was fully attained.

There were areas identified at this surveillance audit that required improvement around complaints, corrective actions, informed consent, medication management systems.

**Outcome 1.1: Consumer Rights**

An open disclosure policy is documented and implemented. The interpreter services are available, if required. The complaints process is made known to residents and families on admission and displayed in the facility. Staff, residents and family interviewed demonstrate an understanding of the complaints process. A complaints register is maintained and up to date. The complaints processes are not consistently completed according to the Code and the policy and this requires an improvement.

Residents’ files reviewed for consent show that general consents are signed for information sharing, treatment outings and photo identification of residents. Consents for advanced directives stating residents are not for resuscitation are currently signed by the enduring power of attorneys and this requires an improvement.

**Outcome 1.2: Organisational Management**

Oceania Care Company, the governing body has established systems in place which define the scope, direction and goals of the organisation and the facility, and the monitoring and reporting processes against these systems. Quality improvement data is reported on to the governing body via the intranet monthly. Monitoring and communication of quality improvement data occurs via the facility’s meetings. Internal audits, satisfaction surveys and meetings are conducted, however the corrective actions are not consistently documented and implemented and this requires an improvement.

The facility is managed by a business and care manager with aged care experience. They are supported by a clinical manager, a registered nurse and a clinical and quality manager from Oceania.

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

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

There is a documented rationale for determining staff levels and staff skill mixes. There is a registered nurse on duty 24 hours a day with on-call support from the business and care manager and the clinical manager.

**Outcome 1.3: Continuum of Service Delivery**

The person centred care plans are developed by the registered nurses, reviewed by the clinical manager and signed by family or the resident. The general practitioner confirms that there are no residents who currently need a higher level of care than provided by the facility. The sampled files evidence residents’ care plans demonstrate a team approach to reviews and evaluations.

The documentation and observations of service delivery demonstrate that consultation and liaison is occurring with other services, sighted referrals to specialists, dietitian and physiotherapy services. The residents' files sampled evidence that evaluations of long term care plans are within the timeframes required and reviewed more frequently if a resident’s condition changes.

Interviews with the activity coordinators and sighting the activities programme confirm the activities programme meets the needs of the service group. The activity coordinators state they have access to appropriate equipment. Residents participating in the activities were sighted on the audit days.

Visual inspection of medication and controlled drug storage areas, evidence an appropriate and secure system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained, evidences weekly checks by registered nurses and the pharmacist completes six monthly physical stock takes of controlled drugs. The resident medicine charts reviewed in the hospital have three monthly medicines reviews completed by the general practitioners, however there is a requirement for improvement relating to three monthly reviews of residents medicine charts to be consistently completed in the rest home.

There are no residents who self-administer medicines. The service has 14 staff members who administer medicines. There is a requirement for improvement relating to all staff members who administer medicines to have documented annual competencies completed.

The service has implemented a seasonal four weekly menu. The menu is developed by the dietitian from support office and reviewed annually, the latest review occurred during April 2014. Kitchen staff members completed food safety training and they are informed by clinical staff members of the dietary needs of residents.

**Outcome 1.4: Safe and Appropriate Environment**

The business and care manager advises there have not been any alterations to the building since the last certification audit. A Building Warrant of Fitness is displayed at the main entrance and expires on 1 July 2015.

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

Restraint folders reviewed during the on-site audit evidence restraint approval is obtained and the service maintains a process to ensure restraint use is safe. Restraint is implemented as last resort to ensure the safety of a resident. The service maintains a restraint register.

**Outcome 3: Infection Prevention and Control**

Policies and procedures document infection prevention and control surveillance processes. The surveillance data is collected, collated and analysed to identify areas for improvement or corrective action requirements. The restraint coordinator who is also a senior registered nurse identifies trends which are analysed and discussed at the monthly infection control and staff meetings. The infection control meeting minutes identify key issues and concerns with key people identified to implement changes.

Infections are resolved quickly. Health care assistants are aware of the need to report signs and symptoms of infection to the registered nurse. All infections are recorded on the data collection sheets, including infections that may not be treated with antibiotics. Results of surveillance are recorded, acted upon and evaluated for effectiveness, sighted surveillance data. Trends are identified and expressed in graphs and charts.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 13 | 0 | 2 | 2 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 2 | 3 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 59 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.10.4 | The service is able to demonstrate that written consent is obtained where required. | PA Moderate | Six out of seventeen advanced directive forms stating the resident is not for resuscitation are signed by the enduring power of attorney. | Provide evidence the advance directive/not for resuscitation forms are signed by competent residents. | 30 |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management  | The right of the consumer to make a complaint is understood, respected, and upheld.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.1 | The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | The three complaints in 2013 do not evidence the complaints are recorded on the complaint forms, as per policy. One of the three complaints does not evidence an acknowledgement is provided in writing within five days of the receipt of the complaint. There is no recorded evidence of the complainants being informed of the availability of an independent advocate in the three of the three complaints. | Provide evidence the complaint processes are implemented to comply with Right 10 of the Code and the policy. | 180 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | (i) Review of internal audits, satisfaction surveys and residents’ meeting minutes evidence that corrective action plans are not being consistently documented, implemented and monitored to address all areas identified as requiring improvement.ii) A sentinel event dated January 2014 does not evidence completed sentinel event action plan form, as per policy.(iii) The name / designation of the person/s responsible for implementation of the corrective action/s and the timeframe/s are not being consistently documented. | Provide documented evidence that:i) The corrective action plans are being developed, implemented, monitored and signed off as having been completed. ii) The sentinel event processes are followed, as per policy.(iii) The name / designation of the person/s responsible for the corrective action plan/s is documented along with timeframes for the corrective actions.  | 180 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Five of sixteen medicines charts in the rest home are not reviewed at three monthly intervals. | All medicine charts to have three monthly reviews completed by the general practitioner. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | There is no recorded evidence that medication competency testing has occurred. | Provide documentation of staff medication competency assessments. | 30 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are policies and procedures in place to support the open disclosure practice in the facility. The incident forms and the residents’ progress notes evidence the family are informed of adverse events or when the resident’s condition alters. The admission agreement contains all the required information.

The four of four residents (two rest home and two hospital) and the three of three family members (one rest home and two hospital) interviewed confirm that the staff and management communicate well with them.

The business and care manager advises there are no residents requiring interpreter services at time of audit.

The district health board contract requirements are met.

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

Consumers have a right to full and frank information and open disclosure from service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Residents and family of their choice are provided with information in order to make informed decisions and therefore give informed consent. Seven of seven resident files reviewed evidence general consent are signed.

One out of seven resident files shows that the enduring power of attorney signed the consent to not resuscitate. The sample size was increased to 17 resident files. Six out of seventeen files have the enduring power of attorney consent to the resident not being resuscitated. Residents and family participate in their recovery, care, treatment and support as well as decision making processes, confirmed at four of four residents ( two rest home and two hospital) and three of three family ( one rest home and two hospital) interviews.

There is a requirements for improvement relating to advanced directives stating that the resident is not for resuscitation to only be signed by the resident who is competent to make the decision.

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

**Evidence:**

The service demonstrates that written consent is obtained where required, sighted seven of seven general consents obtained from residents. One of the seven resident files evidences the advance directive/ not for resuscitation form is signed by the enduring power of attorney (EPOA). The auditor extended the sample size to a total of 17 resident files in respect of not for resuscitation orders. Six of the seventeen resident files evidence the EPOA signed permission not to resuscitate. The service started implementing corrective the action on audit days.

**Finding:**

Six out of seventeen advanced directive forms stating the resident is not for resuscitation are signed by the enduring power of attorney.

**Corrective Action:**

Provide evidence the advance directive/not for resuscitation forms are signed by competent residents.

**Timeframe (days):** 30 *(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 1.1.13: Complaints Management  **(**HDS(C)S.2008:1.1.13)

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The complaints policy and procedure are congruent with Right 10 of the Code of Rights. There is a complaint register, which is current and monitored by the business and care manager. The complaints registers for 2013 and 2014 are reviewed.

There are three internal complaints recorded on the complaints register for 2013 and two external anonymous complaints reported to the Nelson Marlborough District Health Board (NMDHB) in 2014. The first anonymous complaint to the NMDHB occurred in January 2014 and there is evidence of communication by the business and care manager to the NMDHB and communication from the NMDHB that the complaint is now closed. The second anonymous complaint forwarded to the NMDHB, dated February 2014 resulted in a short notice special audit by the Central Region’s Technical Advisory Services (CTAS) in March 2014. There are four issues identified following this special audit relating to conflict of interest; review/ reassessment of residents; safety and security and sentinel event management. A letter from the NMDHB dated 12 May 2014 advises that all the corrective actions arising from the special audit have been met.

The business and care manager states there have not been any other external complaints referred to the Health and Disability Commission, police, coroner, Accident Corporation or Ministry of Health.

The complaints procedure audit was last conducted in May 2014 with 100% compliance. The staff interviews confirm they are aware of the complaints process.

The complaints process documentation is included in the facility information pack, the admission agreement and the complaint forms are located throughout the facility.

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

There is an area requiring improvement relating to the complaint processes to comply with Right 10 of the Code and the policy.

The district health board contract requirements are not fully 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:** PA Low

**Evidence:**

The complaints policy and procedures are congruent with the Right 10 of the Code of Rights. The complaint register is current and monitored by the business and care manager. There are three complaints recorded for 2013 and two external anonymous complaints reported to NMDHB in 2014.

**Finding:**

The three complaints in 2013 do not evidence the complaints are recorded on the complaint forms, as per policy. One of the three complaints does not evidence an acknowledgement is provided in writing within five days of the receipt of the complaint. There is no recorded evidence of the complainants being informed of the availability of an independent advocate in the three of the three complaints.

**Corrective Action:**

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

**Timeframe (days):** 180 *(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:**

The Oceania Care Company Limited has systems in place which record the scope, direction and goals of the organisation and the facility. The monthly non clinical reports to the governing body are provided by the business and care manager and the monthly clinical indicators reports are provided by the care manager, sighted. Oceania values, mission statement and philosophy are displayed at entrance to the facility. The monthly business status reports are provided to the Oceania executive team and the board.

The business and care manager is an experienced aged residential care non clinical manager. They are responsible for the oversight of the facility, financial management, human resources, payroll and rosters. They have been employed at the facility since 1997, previously employed as a health care assistant, then an assistant manager and in 2008 as the manager. They are supported in their role by an experienced clinical manager, registered nurse (RN) who has been in their position since November 2012. The clinical manager is responsible for clinical oversight and staff education and training. Both roles are supported by the Oceania clinical and quality manager (RN). The business and care manager has completed the national diploma in business and has attended professional development related to their role.

All staff requiring practising certificates have current practising certificates, sighted.

Redwood Retirement Village (Redwood) has contracts with Nelson Marlborough District Heath Board (NMDHB) for aged related residential care for hospital services (medical and geriatric), rest home services and aged related residential respite care.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The monthly business status reports are provided to Oceania head office and include: financial performance; occupancy; health workplace; staff turnover; sick leave; staff education/development; performance management; market presence and facility’s projects. The management report that the Oceania clinical and quality manager visits the facility on regular basis and performs facility health check audits.

The quality management system includes current risk management processes. The quality improvement data is collected and collated, however corrective actions plans are not consistently recorded and implemented and this requires an improvement.

An internal audit schedule and completed audits for 2013 and 2014 are reviewed. The quality and risk management data and quality improvement data is reported at the facility’s meetings. Meeting minutes reviewed evidence this. Monthly report of the facility clinical indicators is attached to the minutes of meetings.

Oceania has documented a national suite of policies to guide clinical practice. The policies and procedures reflect current accepted good practice and reference legislative requirements. The clinical staff interviews (four health care assistants and three registered nurses) confirm staff are informed of new / updated policies and staff signing sheet demonstrate staff have read and understand the new/ reviewed policies. The document control policy and procedure for new or reviewed documents is recorded and implemented.

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

The residents and family satisfaction survey was last conducted in July 2014 and the business and care manager states the survey results are in process if being collated. Sighted the results of 2013 resident and family and staff surveys. There is evidence the survey results are collated, however there is no recorded evidence of the actions taken in response to the survey results (refer to 1.2.3.8)

The district health board contract requirements are not fully met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The quality management system includes current risk management processes. The quality and risk management data and quality improvement data is reported at the facility’s meetings.

**Finding:**

(i) Review of internal audits, satisfaction surveys and residents’ meeting minutes evidence that corrective action plans are not being consistently documented, implemented and monitored to address all areas identified as requiring improvement.

ii) A sentinel event dated January 2014 does not evidence completed sentinel event action plan form, as per policy.

(iii) The name / designation of the person/s responsible for implementation of the corrective action/s and the timeframe/s are not being consistently documented.

**Corrective Action:**

Provide documented evidence that:

i) The corrective action plans are being developed, implemented, monitored and signed off as having been completed.

ii) The sentinel event processes are followed, as per policy.

(iii) The name / designation of the person/s responsible for the corrective action plan/s is documented along with timeframes for the corrective actions.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an adverse event reporting system in place. All accident/incidents are recorded and reported on the Oceania intranet as part of the monthly clinical indicators that record incidents relating to absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse.

The communication with families following adverse events, or any change in resident’s condition is evidenced in the residents’ files reviewed and confirmed at family interviews.

The staff education in adverse reporting was last conducted in May 2014 and staff interviews confirm awareness of the adverse event process.

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

The accident /incident audit was last conduced in March 2014 (refer to 1.2.3.8).

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are policies and procedures in relation to human resource management. A competency register and staff education records are maintained, sighted.

There is a planned and documented staff in-service education plan and staff attendance records are maintained, sighted for 2013 and 2014 in-service education plan and staff attendance records. The annual practising certificates are current for all staff who require them to practice.

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

The nine of nine staff files sampled evidence human resources systems are adhered to.

The district health board contract requirements are met.

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are documented staffing rationale policies for determining staffing levels and skill mixes. The staff rosters, timesheets and payroll are managed electronically by the business and care manager. The staff rosters sighted evidence staffing contractual specifications are met. There is sufficient staff to provide care for residents and this was confirmed at staff interviews. The staff interviewed confirm they are able to get through their work. The residents interviewed state the care they receive is appropriate to their needs.

The rosters evidence business and care manager and the clinical manager work Monday to Friday and on call after hours. There is a registered nurse cover 24/7.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Seven resident files are sampled (three in the hospital and four in the rest home). Seven out of seven resident files evidence the stages of service provision developed by the staff members. The services promote continuity of service delivery. Staff member interviews confirm residents and or their family members are involved in all stages of service provision. The person centred care plans (PCCP) are developed by the registered nurses (RN’s), signed by family or the resident and reviewed by the clinical manager, sighted and confirmed at four of four family interviews. Interview with the general practitioner confirms that there are no residents who currently need a higher level of care than provided by the service. Handover in the hospital is observed. The registered nurses cover a wide variety of topics including care, treatment, needs, feedback to family and doctors rounds.

Two of two hospital residents and two of two rest home resident interviews confirm having the opportunity to make input into their person centred care plans. The sampled files (seven out of seven) evidence nursing assessments meet the appropriate timeframes and demonstrate a team approach to reviews and evaluations. There is a requirement for improvement relating to advanced directives stating not for resuscitation (NFR) that are signed by the enduring power of attorney (refer to 1.1.10.4).

Tracer methodology in the rest home

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

Tracer methodology in the hospital

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

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation and observations of service delivery demonstrate that consultation and liaison is occurring with other services, sighted referrals to specialists, dietitian and physiotherapy services. The interventions are consistent with and contribute to meeting the resident’s assessed needs, sighted in seven of seven (three hospital and four rest home) resident files.

The general practitioner (GP) and the RN confirm that treatment and care is based on assessed needs and goals as identified with input of the residents. The person centred care plans include cultural needs, sexuality and spiritual needs, sighted in seven of seven resident files. There is evidence of residents or family signing the PCCP to demonstrate participation in care planning processes, sighted.

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 facility employs two people responsible for activities in the service.

The activities coordinators (AC’s) are responsible for developing the activities programme for both the rest home and the hospital. Both activity coordinators work about 30 hours per week, confirmed during interview with the activity coordinators. Four of four residents, three of three family and staff interviews confirm the activities programme includes input from external agencies, supports ordinary and unplanned / spontaneous activities including festive occasions and celebrations. Rest home residents' meeting minutes evidence residents' discussion in relation to the activities programme - sighted minutes from meetings for February and May 2014, however corrective actions have not been implemented (refer to 1.2.3.8).

Residents' files sampled demonstrate the individual activities service plans are current and demonstrate support is provided, sighted in seven of seven resident files.

Interview with the activity coordinators and sighting the programme confirm the activities programme meets the needs of the service group. The activity coordinators both state they have access to appropriate equipment. Residents participating in the activities is sighted on the audit days. Four of four residents interviewed confirm their past activities are considered and their enjoyment of the activities they choose to participate in. Activities attendance records are maintained and were sighted.

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:**

Seven of seven residents' files sampled evidence that evaluations of long term care plans are within the timeframes and reviewed more frequently if a resident’s condition changes, confirmed during interview with the clinical manager and RN. The care plan evaluations are conducted by the RNs with input from the GP, confirmed at the clinical manager, the RN and GP interviews. Family members are notified of any changes in resident's condition, evidenced in seven of seven residents' files sampled and confirmed at four of four residents and three of three family interviews.

There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required, verified in sampled files. Residents' files evidence referral letters to specialists and multidisciplinary reviews are current, confirmed during the general practitioner interview and sighted in seven of seven resident files.

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 1.3.12: 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:** PA Moderate

**Evidence:**

Visual inspection of medication and controlled drug storage areas, evidence an appropriate and secure system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidences weekly checks by registered nurses. The pharmacist completes six monthly physical stock takes of controlled drugs, sighted entries to the drug register.

Fourteen resident medicines charts are reviewed (eight in the rest home and six in the hospital). It was found that one of the medicines charts in the rest home was not reviewed within the required three monthly timeframe. The auditor extended the sample size of medicines charts in the rest home to 16 files and five out of 16 resident medicines charts have not been reviewed within the required three months. The auditor extended the sample size to 12 in the hospital, all the resident medicines charts had timely reviews completed by the general practitioners.

Residents' medicines charts list all medications a resident is taking (including name, dose, frequency and route to be given). There is evidence staff are signing off, as the dose is administered, sighted during the medication round observed at lunch-time, on the second day of the on-site audit. Of the 14 medicine charts initially reviewed, the GP signs and dates all entries, allergies are recorded, each chart has photo identification and the GP signs, dates and crosses out discontinued medicines.

Thirteen staff authorised to administer medicines. Competency testing includes a written questionnaire and a practical test to verify competency, confirmed during the clinical manager interview, however the records are not signed off. Staff who administer medicines include 11 RN’s, one enrolled nurse (EN) and two health care assistants (HCA’s). Staff education in medicine management was conducted on 24 June 2014.

There are no residents self-administering medicines in the rest home or in the hospital, confirmed at the clinical manager and RN interviews. The service completed internal audits on medicines management in January and May 2014, there are requirements for improvement relating to corrective actions to be implemented (refer to 1.2.3.8) and a requirement for improvement regarding the medicines charts of residents to be reviewed by the general practitioner at three monthly intervals or sooner when the needs of the resident changes. The previous requirement for improvement relating to self -administration of medicines is fully implemented.

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

**Evidence:**

Prescribing, administration, storage, disposal and medicines reconciliation occurs in a safe and appropriate manner however the general practitioner’s review of medicines charts is currently not completed at three monthly intervals.

**Finding:**

Five of sixteen medicines charts in the rest home are not reviewed at three monthly intervals.

**Corrective Action:**

All medicine charts to have three monthly reviews completed by the general practitioner.

**Timeframe (days):** 30 *(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:** PA Moderate

**Evidence:**

Interviews with staff who administer medicines and the clinical manager confirms that competency testing include a theoretical test as well as sign off of a practical medicines round. Fourteen staff members are responsible for medicines administration in the service, including 11 registered nurses, one enrolled nurse and two health care assistants. However there is no hard copy evidence of competency testing having occurred.

**Finding:**

There is no recorded evidence that medication competency testing has occurred.

**Corrective Action:**

Provide documentation of staff medication competency assessments.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Food services policies and procedures are appropriate to the service setting. The service implemented a seasonal four weekly menu, confirmed at the cook interview. The menu is developed by the dietitian from support office and reviewed annually, the latest review occurred during April 2014. Food service staff members have completed food safety training. There are documented protocols for management of residents with unexplained weight gain or weight loss, confirmed during review of seven of seven resident files and RN interviews.

Interview with the cook confirms awareness of residents who have been identified with weight loss, diabetes or other special dietary needs, sighed dietary assessment records in the cooks file and confirmed at interview with kitchen staff / cook. Copies of dietary profiles were reviewed in residents' files sampled. Additional snacks are available for residents when the kitchen is closed, confirmed at four of four resident interviews and three of three family interviews. Resident's nutritional needs and interventions are identified and documented on the person centred care plan, sighted.

Residents interviewed (four of four) were satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided. Food, fridge and freezer temperatures are recorded, sighted. The lunch time meal service is observed and evidences food is prepared in the kitchen, delivered and served immediately. Staff assist resident with food intake, confirmed during three of three family interviews and sighted during the on-site audit days.

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 1.4.2: 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:**

There is a current building warrant of fitness that expired on 1 July 2015. There have not been any alterations to the building since the last certification audit.

##### **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.)*

# 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:**

Four out of four restraint folders reviewed during the on-site audit evidence restraint approval is obtained and the service maintains a process to ensure restraint use is safe. Interview with the clinical manager who is also the restraint coordinator confirms restraint is implemented as last resort to ensure the safety of a resident. The service has eight restraints and three enablers in use at the time of the audit. Restraints and enablers are in the form of bedrails and lap-belts.

The use of enablers are voluntary and the least restrictive option, to ensure the needs of the resident are met and to promote and maintain independence, confirmed at the RN and the restrain coordinator interviews. The service provides education and training regarding challenging behaviour including de-escalation techniques.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures document infection prevention and control surveillance processes. The surveillance data is collected, collated and analysed to identify areas for improvement or corrective action requirements. The RN identifies trends which hare analysed and discussed at the monthly infection control and staff meetings (minutes sighted for April May, June and July 2014). The infection control meeting minutes identify key issues and concerns with key people identified to implement changes within a certain timeframe and once it is achieved, it is signed off, sighted.

The infection control coordinator (ICC) confirms that infections are resolved quickly also confirmed at the general practitioner (GP) interview. Health care assistants (HCA) confirm during interview that they are aware of the need to report signs and symptoms of infection to the RN and to encourage residents who are suffering from urinary tract infections to increase their fluid intake. All infections are recorded on the data collection sheets, including infections that may not be treated with antibiotics, sighted infection control data for January to June 2014.

All staff members have access to meeting minutes, confirmed during HCA and the ICC interviews. Results of surveillance are recorded, acted upon and evaluated for effectiveness, sighted surveillance data. Trends are identified and expressed in graphs and charts.

##### **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.)*