

# Oceania Care Company Limited - Eversley Lifestyle Care & Village

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Current Status: 27 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

Eversley Lifestyle Care provides rest home and dementia level care for up to 50 residents and all beds were occupied on the day of this audit. There are 33 beds in the rest home and 17 beds in the dementia unit. The dementia unit has increased by four beds as four new single bedrooms have been built since the last audit. The facility is operated by Oceania Care Company Limited.

This unannounced surveillance audit was undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the district health board contract. This audit included a review of the three aspects of service provision that were identified as requiring improvement in the previous certification audit in March 2013, all of which have been fully addressed. One new area was identified as requiring improvement during this audit relating to medicine management.

## Audit Summary as at 27 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

Indicator	Description	Definition
	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 27 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.		Standards applicable to this service fully attained.
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### Organisational Management as at 27 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.		Standards applicable to this service fully attained.
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### Continuum of Service Delivery as at 27 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 low risk.
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### Safe and Appropriate Environment as at 27 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.
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### Restraint Minimisation and Safe Practice as at 27 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.
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## Infection Prevention and Control as at 27 August 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Oceania Care Company Limited
<b>Certificate name:</b>	Oceania Care Company Limited - Eversley Lifestyle Care & Village
<b>Designated Auditing Agency:</b>	Health Audit (NZ) Limited
<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Eversley Lifestyle Care & Village
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 27 August 2014 <b>End date:</b> 27 August 2014
<b>Proposed changes to current services (if any):</b>	Facility provides dementia beds. Increase in the size of the dementia unit to 17 by adding four newly built bedrooms.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	50

## Audit Team

<b>Lead Auditor</b>	XXXXXXXX	<b>Hours on site</b>	8	<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXXX	<b>Total hours on site</b>	8	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	16	Total audit hours off site	11	Total audit hours	27
Number of residents interviewed	5	Number of staff interviewed	9	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	34	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 Friday, 5 September 2014

## Executive Summary of Audit

### **General Overview**

Eversley Lifestyle Care provides rest home and dementia level care for up to 50 residents and all beds were occupied on the day of this audit. There are 33 beds in the rest home and 17 beds in the dementia unit. The dementia unit has increased by four beds as four new single bedrooms have been built since the last audit. The facility is operated by Oceania Care Company Limited.

This unannounced surveillance audit was undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the district health board contract. This audit included a review of the three aspects of service provision that were identified as requiring improvement in the previous certification audit in March 2013, all of which have been fully addressed. One new area was identified as requiring improvement during this audit relating to medicine management.

### **Outcome 1.1: Consumer Rights**

Residents and family members interviewed report that services are provided in a manner that respects the residents' rights and facilitates informed choice. They report that they are happy with the service provided and that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and any significant change in a resident's condition. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms.

The business and care manager is responsible for complaints and a complaints register is maintained. The residents and their family members can use the complaints issues forms or raise issues at the residents' meetings. The service provides an environment that is conducive to effective communication and the business and care manager has an 'open door' policy.

### **Outcome 1.2: Organisational Management**

Oceania Care Company Limited is the governing body and is responsible for the service provided at Eversley Lifestyle Care. Planning documents reviewed include a vision statement, values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Eversley Lifestyle Care including regular monthly reporting by the business and care manager and the clinical manager to the Oceania support office. The facility is managed by a suitably qualified and experienced business and care who was appointed to their present position in May 2013. The business and care manager is supported by a clinical manager who is a registered nurse and who is responsible for oversight of clinical care provided.

The Oceania Care Company Limited quality and risk management systems are in place at Eversley Lifestyle Care. There is evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. There is an internal audit programme in place and staff consistently develop and implement robust corrective action plans to address any areas identified as requiring improvement. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events are documented on accident/incident forms and an electronic database that is able to be reviewed by personnel from Oceania's support office.

There are policies and procedures on human resources management and the validation of current annual practicing certificates for personnel who require them to practise is occurring. In-service education is provided for staff at least monthly as well as via one day training programmes that staff are required to attend. Staff members are also supported to complete the New Zealand Qualifications Authority Unit Standards for the 'Certificate in Residential Care' via Tai Poutini Polytechnic. A review of staff records provides evidence that human resources processes are being followed that includes but is not limited to reference checking and criminal record vetting, orientations are being completed and individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of three health care assistants; one in the dementia unit, one in the rest home and a duty leader who provides support and relief in both the dementia unit and the rest home. The business and care manager, the clinical manager and the two other registered nurses share the after-hours on call and the on call registered nurse is clearly marked on the roster. Care staff interviewed report there is adequate staff available and that they are able to get through their work.

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

The service ensures continuity of service delivery through handover at the end of each shift, progress notes and entries to diaries and other records. Residents and family members are involved in the different stages of service provision. Person centred care plans are developed by the registered nurses and signed by family or the resident.

Risk assessments are completed on admission and the person centred care plans include goals, interventions, assessments and six monthly nursing reviews, or sooner where the resident's condition changes. Consultation and liaison is occurring with other services.

The care plan evaluations are documented, resident focused and indicate the degree of response to interventions and the progress towards meeting the resident's goals. The resident files sampled evidence referral forms and letters to nursing and medical specialists.

The activities programme includes input from external agencies, supports ordinary, unplanned and spontaneous activities including festive occasions and celebrations. The residents' meetings are held quarterly.

The breakfast medicines round was observed in the rest home. The general practitioner signs and dates all entries to the medicines charts, allergies are recorded, each chart has photo identification, and discontinued medicines are signed, crossed out and dated. The general practitioner reviews all medicines charts at three monthly intervals, or sooner where necessary. There are no residents who self-administer medicines. All staff members who administer medicines complete annual competency testing.

The controlled drugs are kept in a secure manner. The controlled drug entries into the drug registers are checked weekly by registered nurses and the pharmacist completes a six monthly drug stock-take of controlled drugs. The service monitors the medicines fridge temperatures weekly. The service has a process for returning medicines to the pharmacy.

The food, fluid and nutritional needs of residents are provided in line with recognised guidelines that are appropriate to the residents' needs. The menus are reviewed annually by the dietitian from the support office. Where residents experience unwanted weight-loss, the service provides supplements to assist in weight control.



## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Low			
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 Low	Tablets given during the medicines round were given by the HCA i) using his/her fingers and ii) signed for prior to administering the medicines.	Medicines management processes to be aligned with legislation, protocols and guidelines.	30

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

#### **Evidence:**

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

Residents (five rest home) and family (three dementia) interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care. The business and care manager advises access to interpreter services is available if required via members of staff, the resident's family, the District Health Board and interpreter services. The business and care manager advises they currently have no need for interpreter services.

Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed).

Visual inspection provides evidence the Code of Health and Disability Services Consumers' Rights (the Code) information is readily displayed along with complaint forms.

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 1.1.13: 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 business and care manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes five complaints for 2014 and these are reviewed during this audit.

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

The business and care manager reports there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, District Health Board, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of quality improvement meeting minutes, business and care managers and the clinical manager's monthly reports provide evidence of reporting of complaints.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

#### **Evidence:**

Oceania Care Company Limited (Oceania) is the governing body and is responsible for the service provided at Eversley Lifestyle Care (Eversley). The Oceania quality and risk management systems are fully implemented at Eversley and documented scope, direction, goals, vision, and mission statement reviewed.

Systems are in place for monitoring the service provided at Eversley including regular monthly reporting by the business and care manager and the clinical manager to Oceania support office via intranet and includes quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators, and these are sighted during this audit. The monthly business status reports are sighted and these reports are provided to the Oceania executive team and link to the organisations and the facility's business plan.

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

The business and care manager is a very experienced registered nurse who has worked in management roles in the aged care sector for the last 17 years. The business and care manager was appointed to their current position in May 2013. The business and care manager completed the National Diploma in Business (Aged Care Facility Management) via Tai Poutini Polytechnic in 2012.

The business and care manager is supported in their role by a clinical manager, who is a registered nurse, and who was appointed to this newly created position in February 2014. The clinical manager works up to 20 hours a week and is supported by two other registered nurses: one in the dementia unit who works 20 hours a week and one in the rest home who works 40 hours a week. The registered nurse cover is provided seven days a week. The registered nurses have current practising certificates. The business and care manager's, clinical manager's and the two registered nurse's CVs and personal files are reviewed and there is documented evidence they attend education to keep themselves up-to-date.

The business and care manager, clinical manager and the registered nurses are supported by an Oceania quality and clinical manager as well as a regional business operations manager from Oceania.

Eversley is certified to provide rest home and dementia level care beds and have contracts with the District Health Board (DHB) to provide rest home, dementia, day care and respite services. On the day of this audit there are 17 residents assessed as requiring dementia level care and 33 assessed as requiring rest home level care. One of the residents in the dementia unit is aged less than 65 years but has been assessed as requiring dementia level care.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.2.3: 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:**

A 'Quality Improvement Policy', 'Clinical Risk Management Policy' and a '2014 Quality Audit Schedule' are used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme in place, risks are identified and there is a hazard register. Clinical indicators are documented on an electronic database that is able to be reviewed by personnel from Oceania support office. The Oceania clinical and quality team meet monthly and review the clinical and quality data, review policies and procedures, and clinical documentation.

Relevant standards and legislative requirements are identified and are included in the policies and procedures manuals. Policies and procedures reflect current accepted good practice. Policies and procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff report copies of policies are available in the staff room and they are required to read the policy and sign the staff signing sheet and this is confirmed during review of a folder in the staff room during this audit. The care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via 'Time Target', handover, and via meetings.

The internal audit schedules and completed audits for 2014 are reviewed during this audit. There is comprehensive evidence that indicates corrective action plans are developed, implemented, monitored and signed off to identify any areas identified as requiring improvement. The clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. The review of the quality improvement data provides evidence the data is being collected, collated, evaluated, and comprehensively analysed to identify trends and that this data is being reported to staff and to the governing body. Quality improvement meetings, staff meetings and clinical meetings are held monthly and meeting minutes for 2014 are reviewed. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Staff report during interviews that copies of meeting minutes and print outs of clinical indicators from the Oceania intranet are available for them to review in the staff room. This is confirmed during visual observations during this audit.

A copy of the resident / family satisfaction survey audit outcome completed in August 2013 is reviewed along with a corrective action plan to address the one issue identified. The resident / family satisfaction survey questionnaires have just been distributed for completion in August 2014.

The health and safety manual documents health and safety management systems including a health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements, and an emergency plan. A hazard register is reviewed during this audit. Meeting minutes are reviewed and provide evidence of discussion and reporting on quality improvement data. Oceania holds Workplace Safety Management Practices (WSMP) accreditation at tertiary level for ACC workplace safety and this expires on 31st March 2015.

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

The District Health Board contract requirements are met.

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

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

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

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

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

There is an adverse event reporting system in place. All accident/incidents are recorded on an 'Incident/Accident Reporting Form' and these are reviewed in residents' files. The clinical manager / registered nurse reviews all of the accident/incident forms and enters these accidents and incidents on the Oceania intranet as part of the reporting of monthly clinical indicators. Incidents recorded include but are not limited to incidents relating to absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse. An 'Incident/Accident' internal audit was last completed in March 2014.

The business and care manager advises that one of the registered nurses reviews residents following any falls or injury and that appropriate observations are recorded. This is confirmed during interview of one of the registered nurses and review of resident documentation. The registered nurse also confirms that a review of the resident is undertaken if the resident has two or more falls in a month.

Communication with families following adverse events, or any change in resident's condition is evidenced in the residents' files reviewed. Staff education on falls management and observations and communication is provided via the one day training programme provided for staff. Staff interviewed demonstrate an awareness of the adverse event process.

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:**

Criteria 1.2.7.2 and 1.2.7.3 were identified as requiring improvement during the last certification audit and the improvements have been made.

The business and care manager is responsible for oversight of the in-service education programme with input from the clinical manager. Education for staff is provided via one day training days that all care staff are required to attend every two years. Additional education for staff is provided at least monthly as part of the in-service education programme. Staff education plans, staff competency register and staff education records are maintained and are reviewed for 2013 and 2014.

Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards for the 'Certificate in Residential Care' via Tai Poutini Polytechnic. There are seven care giving staff currently working in the dementia unit and five have completed the dementia specific unit standards. The other two health care assistants are currently working towards completing the dementia specific unit standards.

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

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

Four of four health care assistants interviewed working in the rest home (two) and the dementia unit (two) working morning shifts confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p>There is a documented rationale ('Interim Staffing Policy') for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of three health care assistants; one in the dementia unit, one in the rest home and a duty leader who provides support and relief in both the dementia unit and the rest home. The business and care manager, the clinical manager and the two other registered nurses share the after-hours on call and the on call registered nurse is clearly indicated on the roster.</p> <p>Care staff interviewed report there is adequate staff available and that they are able to get through the work allocated to them. Residents and family members interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit confirms adequate staff cover is provided.</p> <p>The District Health Board contract requirements are met.</p>
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### **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:**

Five resident's files are sampled (two in the rest home and two in the dementia unit). The files evidence the stages of service provision are developed by staff members. Services promote continuity of service delivery. The auditor attends handover in the dementia unit and in the rest home.

Interviews (the clinical manager, registered nurse and four health care assistants) confirm residents and/or family members are involved in the different stages of service delivery. Care plans are developed by the RN's (confirmed during interviews) and signed by family or the resident, sighted in all four resident files. Residents confirm they have input to their person centred care plans. Sampled files evidence nursing assessments meet appropriate timeframes. Family communication sheets are maintained, sighted in four residents' files.

Where records identify an enduring power of attorney (EPOA), the service has legal documentation to support such a role. Resuscitation and consents are signed appropriately.

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 dementia unit

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:**

Observations made of the provision of services and interventions; demonstrate that consultation and liaison is occurring with other services, sighted referral documents in five resident files.

Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the service agreement, sighted by the lead auditor during the on-site audit.

The service implemented a 'third age' contract where they are now employing a specific general practitioner within the community to be the general practitioner for the facility. Interview with the general practitioner, the clinical manager and four residents' files sampled evidence care plans record interventions based on assessed needs, desired outcomes / goals of the residents. The person centred care plans (PCCP's) include cultural needs, sexuality, spiritual needs and residents or relatives are signing the care plans in demonstration of their participation in the care planning process.

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 has a diversional therapist (DT) who has been with the facility for about seven and a half years and an activities coordinator to assist on a Friday, Saturday and Sunday. The DT is working Monday to Thursday (seven hours per day).

The DT is responsible for the development of the programmes for the different areas of service delivery (rest home and dementia), sighted the monthly programmes for January to August 2014.

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

Residents' meeting are conducted by the business and care manager and the DT takes the minutes. The facility is currently conducting a resident's survey with the help of an independent advocate (the results are not collected yet).

Resident's meeting minutes evidence their discussions in relation to loading and un-loading at the front door, food issues, how chairs to be arranged at dining tables, meal sizes, lighting in the dining room, sighted minutes from meeting in August 2014. Residents meeting are being held quarterly, confirmed at the DT interview. The service completed a resident activities programme audit in February 2014 with no requirements for improvement identified, verified.

Five of five residents' files sampled demonstrate the individual activities service plans are current and demonstrate support is provided. Current residents' activities assessments were sighted in all residents' files sampled. Interview with the DT, five residents and three family members confirm the activities programme meets the needs of

the service group and the service has appropriate equipment. Dementia residents participate in group and one-on-one activities where appropriate, sighted during the on-site audit days.

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 are sighted. The DT is currently completing the 'walking in another's shoes' course at the local District Health Board.

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:**

Tracer methodology was carried out on two residents in the service, one in the rest home and one in the dementia unit plus three other resident files were reviewed. Evaluations are documented, resident focussed and indicate the degree of response to interventions and the progress towards meeting the resident's goals.

Residents whose care was followed through have short term care plans reflecting the changes in their needs. All five resident files reviewed show that their assessments reflect their immediate care needs, verified by comparing risk assessments against the person centred care plans.

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 Low

**Evidence:**

Visual inspection of the medication areas in the rest home and dementia unit, evidence an appropriate and secure medicine administration system, free from heat, moisture and light, with medicines stored in original dispensed packs. There is a controlled drug storage area in the rest home, which is secure. The controlled drug register is maintained and evidences weekly checks by the registered nurses. The controlled drug register is checked six monthly as part of the physical stock-take conducted by the pharmacist and noted in the register.

Ten medicines files are reviewed (five in the rest home and five the dementia unit). 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. Medication rounds are observed in rest home.

Sixteen staff members are authorised to administer medicines, all have current competencies signed off; 13 health care assistants (HCA) and three RN's. Staff education in medicine management was conducted in June 2014. The GP signs and dates all entries, allergies are recorded, each chart has photo identification, signs and dates discontinued medicines and the GP consistently completes three monthly reviews of resident's medicines charts.

The previous requirement for improvement relating to GP reviews of medicines charts and recording of allergies on the medicines chart is now fully implemented however, the health care assistant (HCA) administering the medicines at breakfast administered the tablets by hand and signed for the administration prior to giving the medicines. The service does not use standing orders.

There are no residents that self-administer medicines, confirmed during the interview with the clinical manager. There is one requirement for improvement regarding the process involved during medicines administration and signing for medicines prior to administration.

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 Low

**Evidence:**

The breakfast medicines round was observed. The HCA administering the medicines i) tipped the medicines onto the resident's table and gave two tablets to the resident, one-by-one using his/her fingers. The HCA also ii) signed for administering the medicines prior to actually giving the medicines.

**Finding:**

Tablets given during the medicines round were given by the HCA i) using his/her fingers and ii) signed for prior to administering the medicines.

**Corrective Action:**

Medicines management processes to be aligned with legislation, protocols and guidelines.

**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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Food policies and procedures and services are appropriate to the service setting, providing summer and winter menus that rotate every four weeks. The menu is developed by a dietitian, last reviewed in March 2014, confirmed by the chef during interview and sighted.

Food procurement, production, preparation, storage and disposal comply with requirements, sighted food stores and confirmed during visual inspection of the kitchen. The chef keeps daily records of fridge, freezer and chiller temperatures, sighted. Food temperatures are monitored daily.

Resident's individual dietary needs are identified, documented and reviewed as part of the person centred care plan (PCCP) review. The chef is informed when resident's dietary needs change, confirmed during interview and sighted copies of the dietary assessments. Additional food and snacks are available for residents, confirmed during resident and family interviews. Residents, who have excessive weight loss, have their nutritional needs discussed with the chef in order to ensure additional food, high protein and high carbohydrates are being included in the diet. Residents are offered fluids throughout the day, verified.

Residents' files sampled demonstrate regular monthly monitoring of individual resident's weight. The kitchen completed a food survey in the facility during July 2014. Residents and relatives confirm they are mostly satisfied with food and the service is much improved from what it was previously to the facility appointing the chef.

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:**

Four additional single bedrooms have been built in the dementia unit increasing the number of single bedrooms in this unit from 13 to 17. These bedrooms are built on the existing footprint of the laundry, which has been moved off site to another Oceania facility. An additional shower and toilet was also created in this area. A Code Compliance Certificate for these alterations was reviewed during this audit. A Building Warrant of Fitness is displayed at the main entrance that expires on 1 February 2015. There is a secure external area for residents in the dementia unit. Rest home residents have access to external areas that are appropriate to their needs.

There is a reactive maintenance programme in place and regular building inspections are undertaken. There is evidence a preventative maintenance plan is in place and reactive maintenance is occurring. Medical equipment checks are conducted by an external contractor and testing and tagging of electrical equipment is occurring. Visual inspection indicates there is safe storage of medical equipment.

Corridors are wide enough to allow residents to pass each other safely. Safety rails are secure and are appropriately located. Floor surfaces/coverings are appropriate to the resident group and setting.

Staff receive education in the safe use of medical equipment and there is a system in place to review staff competency for specific equipment; for example hoists competency. This was confirmed interview by clinical staff (four health care assistants and two registered nurses) and review of staff education records.

The District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

The business and care manager advises that the approved fire evacuation scheme remains unchanged even though building alterations have been undertaken. The fire evacuation scheme was approved by the New Zealand Fire Service (NZFS) on 5 November 1996. The last trial fire evacuation was held on 26 March 2014 and the next one is scheduled for September 2014.

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

There are at least two designated staff members on each shift with appropriate first aid training.

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

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

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

A visual inspection of the facility provides evidence that emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non-drinkable supply), blankets, and cell phones are available.

Call bells are accessible / within reach, and are available in resident areas (e.g. bedrooms, ablution areas, ensuite toilet/showers). Residents and family interviewed confirm they have a call bell system in place which is accessible and staff respond to it in a timely manner.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

Alternative energy and utility sources are available in the event of the main supplies failing.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

An appropriate 'call system' is available to summon assistance when required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint is actively minimised in the service. There is no use of restraint and one enabler being used, confirmed during interview of the clinical manager, the registered nurse and sighted on the restraint register.

The enabler is in the form of a bedrail and used by a resident in the rest home. Enabler use is voluntary and requested by the person using the enabler. Staff interviews and records evidence restraint minimisation and safe practice (RMSP) as well as challenging behaviour training took place during June 2014.

The District Health Board contract requirement is 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.)

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Surveillance is appropriate for the size and scope of the service. The infection control coordinator (ICC) collects information regarding the resident, the date, what area of the facility the resident resided in, the type of infection, whether a specimen was sent, and outcome of the specimen and whether antibiotics were prescribed and if follow-up was required. Surveillance is carried out monthly, sighted the records for January to August 2014.

Interview with the clinical manager confirms surveillance is carried out in accordance with the service's infection control policies. Management of infections include residents having short term care plans to guide the service. The surveillance data summarise infections and the analysis is expressed in reports to the Oceania support office, sighted records. The clinical manager enters the data into the online infection control logging system namely under the heading 'infections' or 'urinary tract infections'. The system collates the information expressing it as graphs for comparison with previous months and identification of trends. Infection control data is analysed at clinical and quality management level and internally benchmarked.

### **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.)*