

Oceania Care Company Limited - Takanini Lodge

Current Status: 7 August 2014

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

General overview

Takanini Lodge can provide care for up to 91 residents. During the audit there were 82 residents living at the facility including 22 residents at the rest home level of care, 20 in the secure dementia unit and 40 residents at hospital level of care. The business and care manager (registered nurse with a masters degree in management) is responsible for the overall management of the facility and has been in the role for three years. The clinical manager provides clinical oversight and both are supported by the clinical and quality manager who is also a registered nurse. Service delivery is monitored through a quality and risk management programme that included review of complaints, incidents and accidents, surveillance of infections, completion of internal audits, clinical indicator review and satisfaction surveys.

The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads and acuity, with rosters indicating that staffing reflects resident acuity and bed occupancy. There is at least one registered nurse in the service at all times. Residents and family stated that they received a high standard of support.

Improvements are required to medication management.

The service has been given five ratings of continuous improvement for good practice, communication, quality and risk management, planned activities and evaluation of care.

Audit Summary as at 7 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

Indicator	Description	Definition
	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 7 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.		All standards applicable to this service fully attained with some standards exceeded.
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Organisational Management as at 7 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.		All standards applicable to this service fully attained with some standards exceeded.
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Continuum of Service Delivery as at 7 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.
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Safe and Appropriate Environment as at 7 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 7 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 7 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.
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Audit Results as at 7 August 2014

Consumer Rights

Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers' rights, access to advocacy services and the complaint process is available to residents and their family. The residents' cultural, spiritual and individual values and beliefs are assessed and informed consent policy and processes are implemented by the service. Staff ensure that residents are informed and have choices related to the care they receive.

The service has been given a rating of continuous improvement for good practice and communication.

Organisational Management

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

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

There are comprehensive human resources policies with an orientation/induction and training programme implemented. There is a policy for determining staffing and skill mix for safe service delivery with 24-hour registered nursing in the facility.

The business and care manager has extensive experience in aged care and in facility management roles and is a registered nurse. The business and care manager is supported by a clinical manager who has held roles as a clinical manager in another Oceania facility.

The service has been given a rating of continuous improvement for the quality and risk management which leads to improvements in service delivery.

Continuum of Service Delivery

The resident's entry in to the services is facilitated in a competent, equitable, timely, and respectful manner. Each stage of service delivery is undertaken by suitably qualified staff. Annual practising certificates are current. Initial assessments are completed using standardised risk assessment tools. Information pack is provided on admission. Admission agreements are signed on admission. Potential residents are recorded. Declined residents are referred back to the referrer.

The service has an integrated system of documentation. Progress notes reflect the care provided during the shifts. The general practitioner (GP) admitted new residents within time frames. Care plans are developed in a timely manner and are reviewed regularly. Multi-disciplinary reviews are conducted annually. The contents of the hand-over are comprehensive and resident focused.

Activities provided by the service are appropriate to the needs of the rest home, hospital and dementia level care residents.

Referrals are made to specialist medical services as well as other allied health professionals. The policy for transition, exit, discharge or transfer are in place including the use of the yellow envelopes.

Medicines management system is implemented to manage in order to comply with legislation, protocol, and guidelines. There are issues in transcribing, controlled drugs, administration procedure and medication review. There are no expired or unwanted medications identified during the audit. There are two residents who self-administer medicines and the self-administration policy and procedures are implemented.

A resident's individual food, fluids and nutritional needs are met. The resident's food dislikes are noted in the dietary forms including food allergies. Modified diets are provided by the service. All food handling certificates are current. The four week rotating winter and summer menus are reviewed by the dietician annually. Food, fridge and freezer temperatures are conducted daily. The served meals are appropriate for the elderly and serving size is adequate and well presented. Staff are using clean technique in food preparation. They are wearing hair nets, kitchen gloves and aprons. Kitchen is cleaned daily.

The service has been given a rating of continuous improvement for the planned activities and evaluation of interventions delivered.

Safe and Appropriate Environment

All building and plant comply to legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Laundry is outsourced and the managers and staff monitor cleaning to ensure that the facility is clean at all times. There are improvements made in the environment that include an interactive courtyard in the secure dementia area, refurbishment of rooms and additional lighting in all areas. The dementia unit is secure at all times.

Essential emergency and security systems are in place with regular fire drills completed. Call bells are evident across the facility and all are monitored to ensure that they are functioning at all times.

Restraint Minimisation and Safe Practice

The restraint minimisation policy and procedure is implemented by the service. The restraint register is current and one resident uses an enabler. Restraint assessments, restraint consents and restraint monitoring forms are evidence. Risk management plans are in place for all three residents on restraint and three monthly evaluations are evidenced. Restraint minimisation and safe practice is encouraged. The clinical manager is the restraint coordinator. Staff demonstrated good knowledge about restraints and enablers. All staff have current restraint competencies. Restraint in-service educations are conducted and the restraint minimisation policy and procedures are reviewed annually.

Infection Prevention and Control

The infection control programme is appropriate to the size and scope of the service which are reviewed annually. The infection control nurse access resources both within and outside the organisation. Staff are knowledgeable about infection control and prevention. The infection control committee has representatives from different areas within the service. The infection control in-service trainings are provided for all staff. Visitors, families and staff are reminded not to visit their relatives when unwell. There are infection control signages within the service to prevent the spread of infections. Hand gels are available inside the facility and there are adequate hand basins to use by staff and residents.

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 - Takanini Lodge		
Designated Auditing Agency:	Health Audit (NZ) Limited		
Types of audit:	Certification Audit		
Premises audited:	Takanini Lodge		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care		
Dates of audit:	Start date:	7 August 2014	End date: 8 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:	82
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Audit Team

Lead Auditor	XXXXX	Hours on site	16	Hours off site	8
Other Auditors	XXXXX	Total hours on site	16	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				Hours	0

Sample Totals

Total audit hours on site	32	Total audit hours off site	12	Total audit hours	44
Number of residents interviewed	10	Number of staff interviewed	21	Number of managers interviewed	3
Number of residents' records reviewed	10	Number of staff records reviewed	9	Total number of managers (headcount)	3
Number of medication records reviewed	20	Total number of staff (headcount)	76	Number of relatives interviewed	14
Number of residents' records reviewed using tracer methodology	3			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	Not Applicable
g)	Health Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Friday, 22 August 2014

Executive Summary of Audit

General Overview

Takanini Lodge can provide care for up to 91 residents. During the audit there were 82 residents living at the facility including 22 residents at the rest home level of care, 20 in the secure dementia unit and 40 residents at hospital level of care. The business and care manager (registered nurse with a masters in management) was responsible for the overall management of the facility and had been in the role for three years. The clinical manager provided clinical oversight and both were supported by the clinical and quality manager who was also a registered nurse. Service delivery was monitored through a quality and risk management programme that included review of complaints, incidents and accidents, surveillance of infections, completion of internal audits, clinical indicator review and satisfaction surveys.

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Improvements are required to medication management.

The service has been given five ratings of continuous improvement for good practice, communication, quality and risk management, planned activities and evaluation of care.

Outcome 1.1: Consumer Rights

Staffs demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers' rights, access to advocacy services and the complaint process is available to residents and their family. The residents' cultural, spiritual and individual values and beliefs are assessed and informed consent policy and processes are implemented by the service. Staff ensure that residents are informed and have choices related to the care they receive.

The service has been given a rating of continuous improvement for good practice and communication.

Outcome 1.2: Organisational Management

Oceania has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. Quality and risk performance is reported across the facility meetings and monitored by the organisation's management team through the business status reports. Benchmarking reports are produced that include incidents/accidents, infections and complaints. These are used to provide comparisons with other facilities.

There are comprehensive human resources policies with an orientation/induction and training programme implemented. There is a policy for determining staffing and skill mix for safe service delivery with 24-hour registered nursing in the facility.

The business and care manager has extensive experience in aged care and in facility management roles and is a registered nurse. The business and care manager is supported by a clinical manager who has held roles as a clinical manager in another Oceania facility.

The service has been given a rating of continuous improvement for the quality and risk management which leads to improvements in service delivery.

Outcome 1.3: Continuum of Service Delivery

The resident's entry in to the services is facilitated in a competent, equitable, timely, and respectful manner. Each stage of service delivery is undertaken by suitably qualified staff. Annual practising certificates are current. Initial assessments are completed using standardised risk assessment tools. Information pack is provided on admission. Admission agreements are signed on admission. Potential residents are recorded. Declined residents are referred back to the referrer.

The service has an integrated system of documentation. Progress notes reflect the care provided during the shifts. The general practitioner (GP) admitted new residents within time frames. Care plans are developed in a timely manner and are reviewed regularly. Multi-disciplinary reviews are conducted annually. The contents of the hand-over are comprehensive and resident focused.

Activities provided by the service are appropriate to the needs of the rest home, hospital and dementia level care residents.

Referrals are made to specialist medical services as well as other allied health professionals. The policy for transition, exit, discharge or transfer are in place including the use of the yellow envelopes.

Medicines management system is implemented to manage in order to comply with legislation, protocol, and guidelines. There are issues in transcribing, controlled drugs, administration procedure and medication review. There are no expired or unwanted medications during the audit. There are two residents who self-administer medicines and the self-administration policy and procedures are implemented.

A resident's individual food, fluids and nutritional needs are met. The resident's food dislikes are noted in the dietary forms including food allergies. Modified diets are provided by the service. All food handling certificates are current. The four week rotating winter and summer menus are reviewed by the dietician annually. Food, fridge and freezer temperatures are conducted daily. The served meals are appropriate for the elderly and serving size is adequate and well presented. Staff are using clean technique in food preparation. They are wearing hair nets, kitchen gloves and aprons. Kitchen is cleaned daily.

The service has been given a rating of continuous improvement for the planned activities and evaluation of interventions delivered.

Outcome 1.4: Safe and Appropriate Environment

All building and plant comply to legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Laundry is outsourced and the managers and staff monitor cleaning to ensure that the facility is clean at all times. There are improvements made

in the environment that include an interactive courtyard in the secure dementia area, refurbishment of rooms and additional lighting in all areas. The dementia unit is secure at all times.

Essential emergency and security systems are in place with regular fire drills completed. Call bells are evident across the facility and all are monitored to ensure that they are functioning at all times.

Outcome 2: Restraint Minimisation and Safe Practice

The restraint minimisation policy and procedure is implemented by the service. The restraint register is current and one resident uses an enabler. Restraint assessments, restraint consents and restraint monitoring forms are evidence. Risk management plans are in place for all three residents on restraint and three monthly evaluations are evidenced. Restraint minimisation and safe practice is encouraged. The clinical manager is the restraint coordinator. Staff demonstrated good knowledge about restraints and enablers. All staff have current restraint competencies. Restraint in-service educations are conducted and the restraint minimisation policy and procedures are reviewed annually.

Outcome 3: Infection Prevention and Control

The infection control programme is appropriate to the size and scope of the service which are reviewed annually. The infection control nurse access resources both within and outside the organisation. Staff are knowledgeable about infection control and prevention. The infection control committee has representatives from different areas within the service. The infection control in-service trainings are provided for all staff. Visitors, families and staff are reminded not to visit their relatives when unwell. There are infection control signages within the service to prevent the spread of infections. Hand gels are available inside the facility and there are adequate hand basins to use by staff and residents.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	5	44	0	0	1	0	0
Criteria	5	95	0	0	1	0	0

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

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 Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	<p>There are 20 medications charts reviewed with the following findings;</p> <p>I. Three out of 20 reflect transcribing of medications by staff administering medications.</p> <p>II. Three out of 20 are not reviewed by the GP every three months.</p> <p>III. There are four areas either not signed or not countersigned in the controlled drugs register for XXXXX.</p> <p>IV. There are four unsigned areas in the medication signing sheets. The RNs confirm that medications have been administered.</p>	<p>I. All staff must not transcribe medications.</p> <p>II. GP must review all medication charts every three months or as required.</p> <p>III. Staff to follow policies and procedures in relation to controlled drugs.</p> <p>IV. All staff to sign in the medication administration signing sheets after administering medications.</p>	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Standard 1.1.8: Good Practice	Consumers receive services of an appropriate standard.	CI	
HDS(C)S.2008	Criterion 1.1.8.1	The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The business and care manager promotes and leads a quality improvement and risk management programme with the clinical manager providing this for service delivery. The following projects have been completed and evaluated in 2014 evidencing better quality of life for the residents, family and other members of the Takanini Lodge community: a) an improved training programme that extends beyond the Oceania

Code	Name	Description	Attainment	Finding
				<p>training calendar with staff interviewed demonstrating a high level of knowledge and skills; b) improved information given to residents and family on entry following identification of a need for more information through resident and family feedback; c) comprehensive review of the activity programme that includes improvements in the dementia unit with links to behavioural plans; d) documentation of the Takanini Lodge journey since 2012 that includes corrective action plans and projects completed; e) refurbishing and upgrading of the facility including lighting for hallways, cupboards put in to store equipment that has contributed to a decrease in falls and removal of hazards in hallways, refurbishing of rooms and the environment; f) implementation of the homely hotel project; g) landscaping of garden areas with a particular emphasis on the courtyard in the dementia unit which now includes a bus stop, gate, edible garden, planter boxes, mail boxes with mail (residents and family seen using the garden); g) use of quality data with corrective action plans and resolution documented and trends analysed to show a significant improvement in satisfaction and service delivery. There are clinical reviews (a complete review of the resident file) completed for any resident who is identified as having an observed change in condition (reflective practice) with the clinical staff able to change strategies, refer and monitor the resident in the early stages of any change. The general practitioner confirms a high level of confidence in the clinical staff. Projects to improve clinical care have resulted in a decrease in the number of falls for residents with results well evaluated and graphed. The team approach to provision of care as described by the business and care manager, clinical manager, registered nurses and health care assistants interviewed allows any changes in care to be immediately implemented. The handover process observed twice during the audit (registered nurse handover when the registered nurse starts a shift half way through the morning and a handover from morning to afternoon staff) indicates that there is a thorough handover of information that links to progress notes documented and care plans.</p>
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	CI	
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	CI	<p>The service has a philosophy of actively engaging residents and family in discussion that is described by the business and care manager as starting as soon as the individual enters the property. This includes always offering visitors and residents a drink and asking what the person needs. The 10 residents and 11 family interviewed gave many examples of staff communicating with them with three residents/family stating that this was over and above their experiences of communication when in other facilities. Examples described include ringing the family the day after a new resident has been admitted with a detailed summary of how they are, continuing to phone particularly if the</p>

Code	Name	Description	Attainment	Finding
				<p>resident is unsettled or the family is anxious, phoning immediately after an incident e.g. fall, bruise or any changes in health status noting that the wishes of the family are taken into consideration, phoning when there are any appointments being made or if there are specialist visits; inclusion in meetings including care planning and in visits from specialists; meetings with the family weekly if there are any ongoing changes of significant challenging behaviours; calling the family in to help settle the resident if unsettled on agreement with the family. All staff describe a culture of having catch ups with staff when they come in and of staff going through the notes with the resident and family. Family describe being very supported by staff who ask how they are.</p> <p>Staff make a point of establishing the best way to communicate with family members e.g. by email, text, phone. This includes texts and emails sent to the facility that are read to the resident. There are numerous 'thank you' cards and letters of commendation to the service. There is a Oceania Connect rewards programme for staff and there are 18 staff nominated by family between April and June 2014 for rewards. Takanini Lodge also won the award for the Oceania Connect service reward points and three staff have won vouchers for first and third place for points this year. Some residents have their own phones and computers and are supported to use this to communicate with families. There are cordless phones in each wing.</p> <p>There are communication forms in each individual file and these (as well as the progress notes) are updated at each point of communication. Multi-disciplinary team meetings also record evidence of family and resident communication around cares.</p> <p>The service engages in reflective practice that includes a full review of the resident file by the registered nurse and/or clinical manager and or business and care manager whenever there is a resident that has a change in behaviour or needs. It is usually a visual change that includes identification immediately to establish why the resident 'is out of sorts' or their normal routine is different. Monitor behaviours each month and behavioural plans are then developed with strategies to minimise the behaviour/s. The business and care manager and the clinical manager also discuss outcomes and recommendations and these are discussed at the meetings including the registered nurse meetings monthly (minutes sighted). The satisfaction of care is reported on through the MDT meetings that include the resident and the family. The business and care manager, clinical manager and or registered nurses can call an MDT meeting at any time and discuss strategies and management. One review for a resident requiring hospital level care now includes weekly family meetings, support for the family with the family member encouraged to engage in activities.</p> <p>There are six weekly post admission audits and exit interviews and the last results for the last three residents indicate that there is 100% satisfaction with the service. The monthly resident/family meeting minutes reviewed for 2014 confirm that there is very positive feedback and a high level of satisfaction with the service. There are annual satisfaction surveys. The overall 2013 satisfaction survey showed a high level of satisfaction with the service with some areas identified for improvement. Action plans</p>

Code	Name	Description	Attainment	Finding
				<p>were put in place with evidence sighted of improvements made in response to improvements identified. The 2014 satisfaction survey showed an increase in positive feedback with respondents stating that they are satisfied or very satisfied with all areas identified in the survey. The only two comments where a resident/family member indicated a lower level of satisfaction related to missing property (two only). The staff also describe 'taking care of the family member' when they are unwell with staff taking vital signs and taking a family member to the general practitioner when unwell. Staff also describe including the family completely when the resident requires palliative care. A measure of this is the continued involvement in the service by the family even after the resident has passed away. The staff describe following the resident out through the front door when they pass away to recognise the resident and family and to show their continued support.</p> <p>The service has a homely hotel concept that includes a focus on hospitality and customer service. There are many incidents described that are 'over and above' the norm e.g. giving a family breakfast while waiting for their family member to be transported to hospital. Staff describe giving time to family to talk and discuss their feelings/issues and this is confirmed by the residents and family interviewed.</p> <p>The service has a number of residents with English as a second language. One resident in the hospital area also identifies their family member as speaking to them fluently and using this as a preferred language. Four family members interviewed with residents who have English as a second language state that there is excellent communication between staff/residents/family and encouragement for them to come in an interpreter at any time if the resident is unsettled or there is an appointment. They also describe staff using body language, sign language and cards to communicate with residents (sighted). One resident has a board that enables communication to occur. The staff who are able to speak in the same language are assigned to support the resident whenever possible and if they are not supporting the resident on the day will always visit while on shift to 'chat' and ask if the resident needs anything.</p>
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.	CI	
HDS(C)S.2008	Criterion 1.2.3.7	A process to measure achievement against the quality and risk management plan is implemented.	CI	There is extensive monitoring of the service that includes the following: monitoring of complaints, incidents, accidents, health and safety etc. There is a business status report and a dashboard that informs Oceania and the service of progress against all quadrants e.g. financial, service delivery, customer service, staffing. The service benchmarks against other similar services in Oceania with consistently high levels of satisfaction and outcomes. Projects over the past three years have been evaluated to ensure that there

Code	Name	Description	Attainment	Finding
				<p>has been a positive improvement in outcomes with the internal audit programme and the satisfaction surveys continuing to confirm that gains have been sustained. The comprehensive training programme, monitoring of competencies, range of meetings that engage staff and managers at all levels and the team approach to work ensures that staff are fully informed, competent, skilled and knowledgeable with the ability to take on change and engage in projects. An example is the reflection on an individual clinical changes with cases documented following a full review of the resident file. This was originally led by the business and care manager and clinical manager and registered nurses are now proactively completing these and presenting them themselves for discussion. The falls project with trends analysed over two years indicating a significant decrease in falls. Any suggestions, concerns, issues raised through the audit or satisfaction surveys are discussed, analysed and corrective actions put in place. Quality improvement projects continue to be implemented with a focus in the forthcoming year being around a more interactive training session for staff around manual handling, continued renovations of rooms and the development of a sensory modulation room in the dementia unit and in the hospital/rest home area. Projects have targeted specific needs of residents including those in the dementia unit with the development of the interactive courtyard and small lounge area.</p>
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	<p>The activities coordinator and the diversional therapist started the activities review for 2013-2014. Trials are undertaken in the different units. This includes soft ball exercises, doll therapy, sensory lounge and newspaper room. The responses of the residents are documented and evaluated including body movements and facial expressions. Appropriate plans and modifications are documented to reinforce the planned activity. The sensory lounge is decorated with soothing colours and serves as an alternative lounge for residents who are not keen in joining the group activity. This lounge provides sensory input for the residents at the end of the day and serves as a venue for meditation/communion each week. The ball activity is trialled on four residents and dolls are provided in various times to reduce agitation and wandering. The soft ball exercises aim to assess the level of involvement, alertness and interaction of the residents. Other sensory items are noted effective in residents with challenging behaviour. The quality improvement meeting form on March 2014 reflects some improvement in the nine trialled residents and better results are documented. Recommendations are noted in the quality improvement meeting form. After the March 2014 meeting, numerous</p>

Code	Name	Description	Attainment	Finding
				<p>attempts are documented to incorporate Maori aspects and more inputs from the families of the trialled residents. This includes enhancing the Maori cultural aspects as well as celebrating the death of a resident. Matariki festival was also celebrated which links this to the Maori cultural awareness of the service.</p> <p>The service also initiated the concept of “white noise” which is used for a rest home level of care resident when unwell. This provides calming effect to the sick resident as well as it serves like a companion to the resident when alone in the room. It promotes good sleep which facilitates faster recovery of the rest home level of care resident.</p> <p>The service is able to show significant quality improvements that are aimed at improving the activities of the residents in the different units. Residents and families confirm a high level of satisfaction with the service with this reflected in the satisfaction surveys and interviews during the day of the audit. There is also a robust recreation/activities internal audit as evidence in the documentation.</p> <p>The service has been given a rating of continuous improvement in recognition of the activities programme and quality initiatives that are over and above the requirements in the standards.</p>

HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	CI	
HDS(C)S.2008	Criterion 1.3.8.2	Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	CI	<p>The service initiated a clinical practice reflection called general file review. This is a more focused evaluation of a resident who manifests changes in behaviour, eating habits, participation in activities, increased confusion and other observations that might potentially lead to a resident's health deterioration. This includes the current diagnosis, medications, past/present risk assessments, vital signs, laboratory findings, medical notes and documentations from the resident's progress notes/allied health team inputs. Relevant information are taken into consideration to identify the potential factors leading to the current condition. There are sighted clinical practice reflection completed for challenging behaviour, weight loss and falls.</p> <p>The clinical manager and the business and care manager conducted this first reflective practice in 2013. The process begins with identifying the problem, reviewing the resident's file to find documentations relating to the problem, meeting the staff to discuss the resident's identified problem and finding a better intervention to resolve the problem in hand. The relatives and the resident when able are contacted and encouraged to attend the reflective practice review as confirmed by the three interviewed relatives. This is a more thorough review of the resident and the file in addition to the short term and person centred care plans (PCCP) in place. The MDR remains being conducted annually or when necessary while the PCCP remains being evaluated every six months.</p> <p>The registered nurses are now confident and able to conduct independent clinical practice reflection as sighted in the documentation. The four RNs interviewed confirm that they conduct general file review that provides a more focused evaluation of the current identified problem.</p> <p>The service is able to show significant quality improvements that are aimed at ensuring the resident's condition is evaluated in a more in-depth approach that captures vital information's to resolve the identified problem.</p> <p>The service has been given a rating of continuous improvement in recognition of the evaluation of the service delivered to the residents and quality initiatives that are over and above the requirements in the standards.</p>

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Staffs receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. Interviews with the clinical manager, seven of seven health care assistants and four registered nurses confirm their understanding of the Code.

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

The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information. The information pack includes (if relevant) a philosophy for the dementia unit that is to 'provide a safe and therapeutic care of residents in a home-like, comfortable environment that enhances quality of life and minimises risks'. The rights documented in the dementia information book are from the perspective of staff respecting the resident and treating the resident with dignity. The rights are threaded through the information book as each point is discussed e.g. challenging behaviours and the rights of residents and obligations and rights of staff.

Training around the code of rights, privacy and confidentiality and complaints was last provided in March and June 2014 facilitated by the advocate. The auditors noted respectful attitudes towards residents on the day of the audit and family and residents interviewed state that the attitudes of staff is a highlight of the service.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:**Corrective Action:**

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA**Evidence:**

A registered nurse discusses the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code are also held at during the monthly residents' meetings (meeting minutes sighted).

Residents and family interviewed including 10 residents (six rest home and four hospital) and 11 family members (three rest home, four hospital and four dementia unit) confirm their rights are being upheld by the service.

Information regarding the Health and Disability Advocacy Service is clearly displayed in multiple locations throughout the facility and in a brochure that is held at reception. Pamphlets around the Code are available at the front entrance of the service with posters in English and Maori in all areas including the dementia unit. If necessary, staff will read and explain information to residents as stated by the health care assistants and registered nurses interviewed. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.

Ten residents and 11 family members interviewed are able to describe their rights and advocacy services particularly in relation to the complaints process.

An audit of the Code and advocacy in June 2014 shows that the audit achieved 96%.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA**Evidence:**

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a philosophy that promotes dignity and respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values with the registered nurses and clinical manager interviewed stating that the care plans are completed with the resident and family member (confirmed by residents and family interviewed). Interventions to support these are identified and evaluated. Residents are addressed by their preferred name and this is documented in 10 of 10 resident files reviewed (three rest home, four hospital, three dementia unit).

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

The service ensures that each resident has the right to privacy and dignity, which is recognised and respected. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room with a number of small areas and rooms available for family and residents to meet in each area including the dementia unit.

Seven of seven health care assistants interviewed report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirm the residents' privacy is respected. Health care assistants interviewed report that they encourage the residents' independence by encouraging them to be as active as possible. A physiotherapist is available for two days a week to assess and review residents with a physiotherapist assistant supporting residents. Health care assistants assist residents with their activity programmes.

The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. They are committed to provide guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the organisation's mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code. Staff receive mandatory education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation. Staff interviewed are aware of the signs of abuse and neglect and have last had annual training in March and June 2014 facilitated by the advocate from Health and Disability Advocacy Service.

Resident files reviewed (10 of 10) identifies that cultural and /or spiritual values, individual preferences are identified and these are discussed as part of the monthly registered nurse meetings as issues are identified as described by the clinical manager (meeting minutes sighted). There are weekly interdenominational services, weekly Catholic services and a meditation session in the dementia unit weekly. There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.

Four of four families from the dementia unit state that their family member was welcomed into the unit and personal pictures and belongings were put up to assist them to orientate to their new environment.

Ten residents (six rest home and four hospital) and 11 family members (three rest home, four hospital and four dementia unit) state that personal dignity and respect is a cornerstone of the service.

The District Health Board requirements are met.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:**Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)**

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

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

Attainment and Risk: FA**Evidence:**

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

Links to local kaumatua Maori services are documented with Papakura Marae offering support when required. There is also a kaumatua who is able to provide support if needed.

There are seven Maori residents living at the facility during this certification audit. There are five staff member who identify as Maori. Staff describe talking with residents in Maori particularly to one resident who has always communicated in Maori during his life. The family member states that this engages the resident and de-escalates any issues. Staff interviewed report specific cultural needs are identified in the residents' care plans. This is further evidenced in 10 of 10 resident files selected for review.

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

Maori events are linked to the activities programme with a Matariki day held in 2014. This is noted in the satisfaction survey in July 2014 and by two Maori family members interviewed as being a highlight of the activity programme.

The service has links with a Maori funeral director and staff are able to direct family to the service if required. There are also blessings of rooms and staff and relatives and encouraged and supported to say their good byes to the resident and family as part of the grieving process.

The District Health Board requirements are met.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

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

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

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

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

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

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service identifies each resident's personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident is supported to be as independent as possible.

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

One family member of a Muslim resident in the dementia unit states that her relative is well supported and cultural norms are followed including not having pork with staff using family to interpret to make sure that the resident is well supported.

Five family members of residents with English as a second language confirm that cultural needs are well supported with staff visiting and communicating with residents in their own language over the 24-hour period. They also describe using language cards with residents to support interpretation of needs (sighted).

A resident interviewed with English as a second language in the dementia unit states that the service is happy with the family member supporting this.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:**Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)**

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

ARHSS D16.5e

Attainment and Risk: FA**Evidence:**

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

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

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

Interviews with staff including the diversional therapist, the clinical manager, seven of seven health care assistants, four registered nurses and the business and care manager confirm their understanding of professional boundaries, including the boundaries of the health care assistants' role and responsibilities.

Family and visitors are encouraged to visit particularly to residents in the dementia unit with the service providing a welcoming and supportive environment.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA**Evidence:****Finding:**

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: CI**Evidence:**

Takanini Lodge implements Oceania policies to guide practice. These policies align with the health and disability services standards and are reviewed annually. There is a quality framework that supports an internal audit programme. Benchmarking occurs across all the Oceania facilities with Takanini Lodge actively reviewing the data and making improvements as a result.

There is a comprehensive training programme and managers complete management training. The training programme for all staff includes extra topics outside of those identified on the Oceania standard training plan in response to needs identified and projects taking place. The staff interviewed including the seven health care assistants describe sound practice based on policies and procedures, care plans and information given to them via the registered nurses, clinical and business and care managers. Specialised training and related competencies are in place for the registered nursing staff.

There is a comprehensive programme of meetings at a national, regional and service level and this ensures that the quality improvement and risk management programme is monitored with data used to improve service delivery. Projects are undertaken to improve the lives of residents with these evaluated to ensure that outcomes have improved.

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

The general practitioner reports a high standard of care is provided at the service and the registered nurses demonstrate good clinical assessment skills. Consultation is available through the organisation's management team that includes registered nurse, dietician and others as required. A physiotherapist is available for two days a week with a physiotherapist assistant implementing plans.

The service has been given a rating of continuous improvement for good practice.

The District Health Board requirements are met.

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

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

Attainment and Risk: CI**Evidence:**

Finding:

The business and care manager promotes and leads a quality improvement and risk management programme with the clinical manager providing this for service delivery. The following projects have been completed and evaluated in 2014 evidencing better quality of life for the residents, family and other members of the Takanini Lodge community: a) an improved training programme that extends beyond the Oceania training calendar with staff interviewed demonstrating a high level of knowledge and skills; b) improved information given to residents and family on entry following identification of a need for more information through resident and family feedback; c) comprehensive review of the activity programme that includes improvements in the dementia unit with links to behavioural plans; d) documentation of the Takanini Lodge journey since 2012 that includes corrective action plans and projects completed; e) refurbishing and upgrading of the facility including lighting for hallways, cupboards put in to store equipment that has contributed to a decrease in falls and removal of hazards in hallways, refurbishing of rooms and the environment; f) implementation of the homely hotel project; g) landscaping of garden areas with a particular emphasis on the courtyard in the dementia unit which now includes a bus stop, gate, edible garden, planter boxes, mail boxes with mail (residents and family seen using the garden); g) use of quality data with corrective action plans and resolution documented and trends analysed to show a significant improvement in satisfaction and service delivery. There are clinical reviews (a complete review of the resident file) completed for any resident who is identified as having an observed change in condition (reflective practice) with the clinical staff able to change strategies, refer and monitor the resident in the early stages of any change. The general practitioner confirms a high level of confidence in the clinical staff. Projects to improve clinical care have resulted in a decrease in the number of falls for residents with results well evaluated and graphed. The team approach to provision of care as described by the business and care manager, clinical manager, registered nurses and health care assistants interviewed allows any changes in care to be immediately implemented. The handover process observed twice during the audit (registered nurse handover when the registered nurse starts a shift half way through the morning and a handover from morning to afternoon staff) indicates that there is a thorough handover of information that links to progress notes documented and care plans.

Corrective Action:

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

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

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

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

Attainment and Risk: CI**Evidence:**

Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced in 20 of 20 completed accident/incident forms.

Family contact is recorded in residents' files – sighted in 10 of 10 files reviewed.

Interviews with 11 family members (three rest home, four hospital and four dementia unit) confirm they are kept informed. Family also confirm that they are invited at least six monthly to the care planning meetings/MDT (multi-disciplinary team meetings) for their family member.

Family interviewed confirm that they are invited to attend the monthly resident meetings.

Interpreter services are available when required from the District Health Board and the staff use family members to interpret when needed. Staff also interpret and communicate with family on a day to day basis with staff identifying as having a range of ethnicities/language including Fijian, Indian, Samoan, Chinese, Philippino, South African.

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

Staff have had training around communication in January 2013 and 2014.

Staff have had training around open disclosure last in March 2014 and training around the complaints process in July 2013.

Family members throughout the facility including the dementia unit are encouraged to communicate with staff, to ask questions and to engage in care planning and MDT meetings. The service is given a rating of continuous improvement for their ability to communicate with family and residents including use of reflective practice and evaluation of communication through six weekly post entry satisfaction surveys and annual satisfaction surveys.

The District Health Board 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: CI

Evidence:

Finding:

The service has a philosophy of actively engaging residents and family in discussion that is described by the business and care manager as starting as soon as the individual enters the property. This includes always offering visitors and residents a drink and asking what the person needs. The 10 residents and 11 family interviewed gave many examples of staff communicating with them with three residents/family stating that this was over and above their experiences of communication when in other facilities. Examples described include ringing the family the day after a new resident has been admitted with a detailed summary of how they are, continuing to phone particularly if the resident is unsettled or the family is anxious, phoning immediately after an incident e.g. fall, bruise or any changes in health status noting that the wishes of the family are taken into consideration, phoning when there are any appointments being made or if there are specialist visits; inclusion in meetings including care planning and in visits from specialists; meetings with the family weekly if there are any ongoing changes of significant challenging behaviours; calling the family in to help settle the resident if unsettled on agreement with the family. All staff describe a culture of having catch ups with staff when they come in and of staff going through the notes with the resident and family. Family describe being very supported by staff who ask how they are.

Staff make a point of establishing the best way to communicate with family members e.g. by email, text, phone. This includes texts and emails sent to the facility that are read to the resident. There are numerous 'thank you' cards and letters of commendation to the service. There is a Oceania Connect rewards programme for staff and there are 18 staff nominated by family between April and June 2014 for rewards. Takanini Lodge also won the award for the Oceania Connect service reward points and three staff have won vouchers for first and third place for points this year. Some residents have their own phones and computers and are supported to use this to communicate with families. There are cordless phones in each wing.

There are communication forms in each individual file and these (as well as the progress notes) are updated at each point of communication. Multi-disciplinary team meetings also record evidence of family and resident communication around cares.

The service engages in reflective practice that includes a full review of the resident file by the registered nurse and/or clinical manager and or business and care manager whenever there is a resident that has a change in behaviour or needs. It is usually a visual change that includes identification immediately to establish why the resident 'is out of sorts' or their normal routine is different. Monitor behaviours each month and behavioural plans are then developed with strategies to minimise the behaviour/s. The business and care manager and the clinical manager also discuss outcomes and recommendations and these are discussed at the meetings including the registered nurse meetings monthly (minutes sighted). The satisfaction of care is reported on through the MDT meetings that include the resident and the family. The business and care manager, clinical manager and or registered nurses can call an MDT meeting at any time and discuss strategies and management. One review for a resident requiring hospital level care now includes weekly family meetings, support for the family with the family member encouraged to engage in activities.

There are six weekly post admission audits and exit interviews and the last results for the last three residents indicate that there is 100% satisfaction with the service. The monthly resident/family meeting minutes reviewed for 2014 confirm that there is very positive feedback and a high level of satisfaction with the service. There are annual satisfaction surveys. The overall 2013 satisfaction survey showed a high level of satisfaction with the service with some areas identified for improvement. Action plans were put in place with evidence sighted of improvements made in response to improvements identified. The 2014 satisfaction survey showed an increase in positive feedback with respondents stating that they are satisfied or very satisfied with all areas identified in the survey. The only two comments where a resident/family member indicated a lower level of satisfaction related to missing property (two only).

The staff also describe 'taking care of the family member' when they are unwell with staff taking vital signs and taking a family member to the general practitioner when unwell. Staff also describe including the family completely when the resident requires palliative care. A measure of this is the continued involvement in the service by the family even after the resident has passed away. The staff describe following the resident out through the front door when they pass away to recognise the resident and family and to show their continued support.

The service has a homely hotel concept that includes a focus on hospitality and customer service. There are many incidents described that are 'over and above' the norm e.g. giving a family breakfast while waiting for their family member to be transported to hospital. Staff describe giving time to family to talk and discuss their feelings/issues and this is confirmed by the residents and family interviewed.

The service has a number of residents with English as a second language. One resident in the hospital area also identifies their family member as speaking to her fluently and using this as a preferred language. Four family members interviewed with residents who have English as a second language state that there is excellent communication between staff/residents/family and encouragement for them to come in an interpret at any time if the resident is unsettled or there is an appointment. They also describe staff using body language, sign language and cards to communicate with residents (sighted). One resident has a board that enables communication to occur. The staff who are able to speak in the same language are assigned to support the resident whenever possible and if they are not supporting the resident on the day will always visit while on shift to 'chat' and ask if the resident needs anything.

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:**Corrective Action:**

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

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

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

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

Attainment and Risk: FA**Evidence:**

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

All resident files identify that informed consent forms are documented and signed.

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

The service information pack includes information regarding informed consent.

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

The advance directive and consent policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of 10 of 10 files note that all have appropriately signed advanced directives. All have been signed on the day of admission.

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

The District Health Board requirements are met.

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

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

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

Finding:**Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)**

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

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

Attainment and Risk: FA**Evidence:**

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

Meeting minutes indicate that information is regularly provided to the residents regarding their right to access advocacy services through the Health and Disability Advocacy Services. Staff training on the role of advocacy services is included in training on the Code and advocacy services – last provided for staff in March and June 2014.

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

The resident file includes information on resident's family/whanau and chosen social networks.

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

The District Health Board requirements are met.

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

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

Attainment and Risk: FA**Evidence:****Finding:**

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

Fourteen families interviewed confirm they can visit at any reasonable time and are always made to feel welcome. Family members of residents in the dementia unit state that staff take extra time to ensure that their needs are met and support them to be with their family member.

Family were seen coming and going freely on the days of the audit with fourteen family members interviewed on the first day of the audit and many other families available to be interviewed if the auditors had requested.

Residents are encouraged to be involved in community activities and maintain family and friends networks. Links are also encouraged through church with some residents still engaged in community activities including attending their own church services. The service activity programme includes performing groups who entertain residents. Residents are included in shopping visits and outings with families.

The District Health Board requirements are met.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

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

Two complaints lodged in 2014 are selected for review. There is documented evidence of time-frames being met for responding to these complaints. The complaint lodged with the Health and Disability Commissioner in June 2014 has been extensively investigated by the business and care manager with the documentation indicating that the service has followed a very robust process that has engaged the family member at all points. The family member has documented approval of the process and the successful completion of the investigation with no issues requiring corrective action. The Health and Disability Commission has closed off the complaint with no recommendations in July 2014. The business and care manager states that there have been no other complaints with the Health and Disability Commission since the last audit or with other authorities.

Ten residents (six rest home and four hospital) and 11 family members (three rest home, four hospital and four dementia unit) state that they would feel comfortable complaining. One family member states that a complaint had been made and this has been addressed through discussions with the business and care manager.

The information pack includes comprehensive information around dementia with four family members in the dementia unit stating that this is useful in guiding their interactions and understanding of behaviour and needs. The information includes the service philosophy and practices particular to the unit including the need for a safe environment for self and others, how behaviours different from other residents are managed and specifically designed and flexible programmes, with an emphasis on behaviour management and the complaints policy.

All resident admission agreements are signed on the day of admission.

The District Health Board 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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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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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:

Takanini Lodge is part of the Oceania group with the executive management team including the CEO (chief executive officer), general manager, operations manager, regional operational managers and clinical and quality manager providing support to the service. Communication between the service and managers takes place on a monthly basis as stated by the service manager interviewed.

Oceania has a clear mission, values and goals. The vision is to be the provider of choice for senior New Zealanders of care and lifestyle options in a way that meets and exceeds the expectations of our residents, staff and stakeholders. The mission is 'we provide excellent contemporary care that reflects our residents' individuality and their right to choice, respect and dignity. We provide a positive and welcoming environment in which our residents are encouraged and supported to improve their quality of life' – documented in service information. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

The facility can provide care for up to 91 residents (22 rest home specific beds, 48 hospital beds with eight beds included as dual purpose beds and 21 dementia beds). During the audit there are 82 residents living at the facility including 22 residents at the rest home level of care, 40 residents at hospital level of care and 20 requiring dementia level of care.

The business and care manager is responsible for the overall management of the facility and has been in the role for three years. The business and care manager is a registered nurse (with current annual practicing certificate), has a post graduate diploma in business and administration, a masters in management and over 15 years' experience in aged care management and further registered nurse experience in colo-rectal nursing in the District Health Board. The business and care manager sits on a number of external committees including the Manukau Institute of Technology training committee and the NDPU meetings representing aged care. Professional development relating to the management of an aged care facility exceeds eight hours with the business and care manager also having completed the Oceania certificate in quadrant leadership.

The business and care manager is supported by the regional operations manager and the clinical and quality manager who has a bachelor of science with a specialist practice in nursing (UK), has been working in aged care for over 20 years including 12 years aged care management in New Zealand – sighted in the file of the business and care manager reviewed.

The District Health Board 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.

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

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.

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

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

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

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

Attainment and Risk: FA

Evidence:

In the absence of business and care manager, a clinical manager is in charge with support from the clinical and quality manager. The current clinical manager has is a registered nurse with a current annual practicing certificate, has a diploma in facility management and has over five years' experience in aged care with two of these as a clinical leader/manager in Oceania facilities. The clinical manager also has two years' experience as a registered nurse in intensive care in the Philippines.

The clinical and quality manager provides support to eight Oceania facilities and provides support for the clinical manager in the absence of the business and care manager as required.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: CI**Evidence:**

Takanini Lodge uses the Oceania quality and risk management framework that is documented to guide practice. The business plan is documented and reported on through the business status reports. This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products.

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

Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme with a corrective action plan documented and evidence of resolution of issues.

All staff interviewed including seven health care assistants, the activities coordinator, the diversional therapist, four registered nurses, the maintenance staff, the clinical manager, housekeeping staff and the business and care manager report they are kept informed of quality improvements.

There are annual family and resident satisfaction surveys which last took place in July 2014. The overall level of satisfaction rate of residents and families is satisfactory to very satisfactory with improvements made following recommendations made in the 2013 satisfaction survey.

The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures, and a health and safety plan are in place for the service. There is a hazard management programme documented 2013-14 with a hazard register documented. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.

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

There are monthly meetings held across the service including quality, staff, infection control, resident/family, restraint and regular meetings for each group of staff e.g. registered nurse, maintenance, activities, housekeeping. All aspects of the quality and risk management programme are discussed through the meetings with significant evidence that improvements are made as a result of data collected and analysed.

There is a monthly newsletter and a Community Connect newsletter from the organisation. This keeps residents up to date with changes in the service and wider organisation.

The service is able to show significant quality improvements that are aimed at improving the lives of residents. Residents, family and the general practitioner interviewed confirm a high level of satisfaction with the service with this reflected in the meeting minutes, through interviews and through the internal audit programme. There is also a robust layer of monitoring of service delivery from the management team and through the quality programme.

The service has been given a rating of continuous improvement in recognition of the ongoing quality and risk management programme that has improved the lives of residents.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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.

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

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.

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

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: CI**Evidence:****Finding:**

There is extensive monitoring of the service that includes the following: monitoring of complaints, incidents, accidents, health and safety etc. There is a business status report and a dashboard that informs Oceania and the service of progress against all quadrants e.g. financial, service delivery, customer service, staffing. The service benchmarks against other similar services in Oceania with consistently high levels of satisfaction and outcomes. Projects over the past three years have been evaluated to ensure that there has been a positive improvement in outcomes with the internal audit programme and the satisfaction surveys continuing to confirm that gains have been sustained. The comprehensive training programme, monitoring of competencies, range of meetings that engage staff and managers at all levels and the team approach to work ensures that staff are fully informed, competent, skilled and knowledgeable with the ability to take on change and engage in projects. An example is the reflection on an individual clinical changes with cases documented following a full review of the resident file. This was originally led by the business and care manager and clinical manager and registered nurses are now proactively completing these and presenting them themselves for discussion. The falls project with trends analysed over two years indicating a significant decrease in falls. Any suggestions, concerns, issues raised through the audit or satisfaction surveys are discussed, analysed and corrective actions put in place. Quality improvement projects continue to be implemented with a focus in the forthcoming year being around a more interactive training session for staff around manual handling, continued renovations of rooms and the development of a sensory modulation room in the dementia unit and in the hospital/rest home area. Projects have targeted specific needs of residents including those in the dementia unit with the development of the interactive courtyard and small lounge area.

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.

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

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.

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

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

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

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

Attainment and Risk: FA

Evidence:

The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are no times since the last audit when authorities have had to be notified. There have been no outbreaks since the last audit.

The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the clinical manager, business and care manager and clinical and quality manager.

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

Twenty incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event.

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

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:

All registered nurses, the business and care manager and the clinical manager hold current annual practising certificates. Visiting practitioner's practising certificates include the general practitioner, pharmacists, dietitian, podiatrist and physiotherapists.

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

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract. The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies. Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

Health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and health care assistants who administer medicines to residents. Other competencies are completed including hoist, oxygen use, hand washing, wound management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower. Five health care assistants specifically asked describe a thorough orientation that was supportive and included being buddied by a senior staff member.

The organisation has a mandatory education and training programme with sessions held monthly. Staff attendances are documented and there is evidence of good staff attendance. The seven health care assistants state that they value the training. Education and training hours exceed eight hours a year.

There are six caregivers who work in the dementia unit and all have completed the required dementia standards. Fourteen other staff have also completed training in dementia care including registered nurses and the activities coordinator.

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.

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy (82 residents currently in the service).

There are four registered nurses on in the morning (two in the hospital (one of whom works from 11am-7pm; one in the rest home area and one in the dementia unit) and two registered nurse in the afternoon and one at night.

There are two health care assistants in the morning/afternoon/night in the dementia unit, four in the rest home in the morning and afternoon and one at night and din the hospital, there are five health care assistants in the morning, three in the afternoon with a four hour shift as well and two over night.

The business and care manager works full-time Monday – Friday and the clinical manager (registered nurse) works full-time.

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

There are currently 76 staff including the business and care manager, clinical manager, 13 registered nurses, diversional therapist and one activities coordinator across all areas with a focus of activities in the dementia unit at times when residents most need to engage in activities (research and evidence based), maintenance, one laundry, three cleaners, physiotherapy assistant, contracted physiotherapist for six hours over two days and 56 health care assistants.

The District Health Board contract requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

Resident files are protected from unauthorised access by being locked away in an office. Informed consent is obtained from residents/family/whanau on admission to display photographs. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

Individual resident files demonstrate service integration. This includes medical care interventions. Medication charts are in a separate folder with medication and this is appropriate to the service.

The District Health Board contract requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA**Evidence:**

The resident's entry in to the services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. Each stage of assessment, planning, provision of care and review/evaluation is undertaken by suitably qualified staff that is competent to perform their role. Annual practising certificates are sighted for all staff that require them. The 10 out of 10 reviewed resident's files confirm that registered nurses (RNs) conduct the initial assessment and develop the initial person centred care plan. The clinical manager (CM) is InterRAI competent and holds the current position for almost two years.

The 10 residents and 14 relatives interviewed stated that they receive information packs and sufficient informations are provided to them prior to and on entry to the service. The information pack include what the service provides, the code of rights, complaints process and advocacy services. The CM reports that needs assessments are required prior entry to the facility.

The admission agreement aligns with the ARC contract. The 10 out of 10 reviewed resident files have signed admission agreements.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The facility has an enquiry folder that keeps both walk in and telephone enquiries. The administrator keeps the enquiry folder in the reception area. There is a section in the enquiry form which records the reason for declining entry to the service. The CM reports that they decline resident's entry to their service when the resident does not qualify the level of care they provide. The CM also mentions that in the event that they cannot accept the resident due to a different level of care requirement, they refer the resident to another service either within the area or to another facility that can meet the resident's level of need. The records of declined potential residents are sighted in the enquiry folder. Declined residents are also referred back to the referrer in a timely manner to discuss other referral options especially in the case of telephone enquiries.

A policy on declining entry to the service is sighted.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes/goals. There is a policy and process that describe resident's admission and assessment procedures. The clinical manager (CM) or registered nurses (RNs) undertake the assessments on admission using standardised tools. The initial risk assessment tools and ongoing assessments include cognition, mobility, safe handling, tinetti, waterlow, abbey pain, cornell depression, oral, dietary, continence, pain, cultural and recreation. An initial plan of care is also developed on admission and sighted in 10 out of 10 reviewed resident's files to provide guidance to all staff in managing the new resident. The admission information, medical notes, allied notes, progress notes, staff inputs as well as resident/family inputs form the basis of the long-term care plan developed within three weeks of admission. The activities assessment is completed within three weeks of admission. Medical assessments are completed within 24-48 hours of admission by the general practitioner (GP) in all 10 reviewed resident's files. The GP examines the residents either monthly or three monthly depending on the resident's level of needs and this is documented in the medical notes. The CM reports that hospital residents are examined monthly or more frequently as required as evidence in five hospital and two rest home levels of care resident's files.

There is a verbal hand-over between shifts as witnessed during the day of the audit. The contents of the hand-over is very comprehensive to ensure continuity of care. Residents on antibiotics, hospital appointments, required procedures and other vital information's are handed over to the next shift with utmost confidentiality.

Short term care plans are sighted in all 10 out of 10 reviewed residents' files. Assessments are documented in the progress notes when residents manifest signs and symptoms of infections. Resolution of the acute condition is documented in the short term care plan. Progress notes are maintained and documented in each shift. All 10 out of 10 reviewed resident's files identify integration of allied professionals including GP, RNs, health care assistants (HCAs), physiotherapy and other specialists. Hospital discharge letters and specialist letters and referrals are sighted in the resident's files including wound referral, speech language therapy and mental health services. The CM

reports that they verbally refer residents to the physiotherapist.

The 10 out of 10 reviewed resident's files evidence that the person centred care plans (PCCPs) are based on the assessed needs of the residents. These PCCPs are recorded on a standardised template that reflect the current needs and desired outcomes of the residents. The PCCP is individualised and identifies the need, assistance required, special instructions and goals. There is an ongoing six monthly evaluations sighted in 10 out of 10 reviewed resident's files. Post fall assessments are consistently completed by RNs for all five incidents of falls. A multi-disciplinary review (MDR) process is conducted six monthly and the outcome of the review is communicated to the resident's family via correspondence, email or telephone as sighted in the communication records in 10 out of 10 reviewed resident's files.

Tracer Methodology 1- Rest home level of care

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

Tracer Methodology 2 – Hospital level of care

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

Tracer Methodology 3 – Dementia level of care

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

The District Health Board 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.

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

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.

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

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

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

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

Attainment and Risk: FA

Evidence:

The clinical manager (CM) or the registered nurses (RNs) undertake a comprehensive initial assessment on admission using standardised tools. The initial risk assessment tools and ongoing assessments include cognition, mobility, safe handling, tinetti, waterlow, cornell depression, abbey pain, oral, dietary, continence, pain, cultural and recreation. Baseline vital signs and weights are taken on admission and recorded. The data collected during the assessment are utilised to develop the initial plan of care for the resident with the involvement of the resident and/or family. The resident's preferences including food, linens and sleeping habits are clearly documented in all 10 reviewed resident's files. The information's gathered by the RNs serve as the basis for the person centred care plans of the residents.

The CM and RNs ensure that the new resident and their family if involved are orientated to the facility including meal times, how to reach staff, complaints process and other relevant information which they require to settle in their new home.

The GP admits the new resident within 24-48 hours and completes a medical assessment as sighted in all 10 reviewed files. The CM is InterRAI competent and is able complete assessments for five residents (three hospital and two rest home levels of care). The triggers in the InterRAI assessments are linked to the PCCP to address the potential or current problem of the five sampled residents.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The initial assessment forms the basis for the person centred care plans (PCCPs) developed within three weeks of admission as sighted in 10 out of 10 reviewed resident's files. The triggers in the InterRAI assessments are linked to the PCCPs as evidence in the five resident's files. There is evidence that the PCCPs are developed with the resident and/or with their families. Resident needs, goals, objectives and interventions are identified, agreed and care to be delivered is explained with the resident when able as well as with the resident's family. The 10 PCCPs sighted cover all areas to support the identified needs of the resident.

Short term care plans are developed when residents have infections as sighted in 10 out of 10 reviewed resident's files. The plans are specific and resident-focused. The CM and/or RNs update both PCCPs and short term care plans depending on the resident's response to the planned interventions and treatment regimen.

The service delivery plans demonstrate integration system. The GP, RNs, health care assistants, physiotherapist, diversional therapist and other allied personnel write in the progress notes. The inputs from the members of the health team are sighted in 10 out of 10 reviewed resident's files. The physiotherapist's rehabilitation plans for the five residents (three in the hospital and two rest home) requiring physiotherapist inputs are sighted in their files.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service provides rest home, hospital and dementia levels of care. They also provide care for younger people with disability (YPD) as well as respite services. Individualised and resident-focused PCCPs are developed by the CM and RNs. When a resident’s condition changes, the CM and/or RNs initiate a review and if required, a consultation with the GP or with the specialist. All 10 out of 10 interventions in the PCCPs are well documented and sufficiently detailed strategies are sighted to address the desired outcome/goal of the resident. The physiotherapists and a physiotherapist assistant are actively involved to maintain and improve the resident’s mobility. The mobility section of the PCCP reflects the inputs from the physiotherapists in five residents file requiring extensive physiotherapist input.

The facility have sufficient equipment’s like hoists, wheelchairs and handling belts to transfer or to assist residents to mobilise. There is an adequate supply of dressings, continence products and linen for residents for staff to use.

Pain assessments and evaluations are sighted for the five reviewed resident files on controlled drugs and regular analgesia. The effectiveness of pain relief is documented in the progress notes and handed-over when requires monitoring and evaluation. There are vital signs, blood sugar levels, fluid balance and weight monitoring forms sighted. The CM and RNs can access the GP when medical issues arise or when there is a change in the resident’s current condition, suspected infections, medication requests/clarifications. The GP confirms that the RNs contact the surgery when required and implements orders with utmost efficiency. The GP verbalises confidence on the nursing staff. The CM refers the residents to other specialists like speech language, dietitian and mental health services when required as sighted in the resident’s files.

The 10 residents interviewed state that their needs are being met and they are receiving appropriate clinical, medical and personal care. The 14 relatives interviewed confirmed the resident’s statements and verbalised that they are very satisfied with the care provided by the service.

The District Health Board 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: CI

Evidence:

The activities for the residents are planned by the activities coordinator with the help of the qualified diversional therapist (DT). They utilise previous activities that are appropriate for the level of involvement of the residents in the rest home, hospital and dementia units. The programme includes activities that are physical, intellectual, spiritual, sensory, social and fun. There are group activities for crafts, paintings and drawings. An entertainer visits the facility every month. The service takes the residents for bus trips, outings, cafes, library visits and shopping by a designated driver. The van driver holds a current first aid certificate and first aid supplies are sighted in the van during the audit.

The activities coordinator develops the activities plan using the recreation assessment during admission. There is a section in the PCCP for the activities plan for 10 out of 10 reviewed resident's files. Activities involvement of the residents is monitored by the activities coordinator in the rest home and hospital units while the diversional therapist predominantly works in the dementia unit. Both the activities coordinator and DT use an attendance checklist. The timeline of weekly activities are available and posted in the activities boards and in the main entrance.

The 10 residents interviewed verbalise that the activities provided for them by the activities coordinator and diversional therapist is enjoyable, stimulating and tailored to their needs as well as for the group. Residents participate in their preferred activities and this is documented in 10 out of 10 reviewed activities plans in the PCCP. Residents in the

dementia unit have different activities during the two days of audit. There are students assisting the residents in the dementia unit. The residents appear to be enjoying the massage and participation is evident.

The District Health Board 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: CI

Evidence:

Finding:

The activities coordinator and the diversional therapist started the activities review for 2013-2014. Trials are undertaken in the different units. This includes soft ball exercises, doll therapy, sensory lounge and newspaper room. The responses of the residents are documented and evaluated including body movements and facial expressions. Appropriate plans and modifications are documented to reinforce the planned activity. The sensory lounge is decorated with soothing colours and serves as an alternative lounge for residents who are not keen in joining the group activity. This lounge provides sensory input for the residents at the end of the day and serves as a venue for meditation/communion each week. The ball activity is trialled on four residents and dolls are provided in various times to reduce agitation and wandering. The soft ball exercises aim to assess the level of involvement, alertness and interaction of the residents. Other sensory items are noted effective in residents with challenging behaviour.

The quality improvement meeting form on March 2014 reflects some improvement in the nine trialled residents and better results are documented. Recommendations are noted in the quality improvement meeting form. After the March 2014 meeting, numerous attempts are documented to incorporate Maori aspects and more inputs from the families of the trialled residents. This includes enhancing the Maori cultural aspects as well as celebrating the death of a resident. Matariki festival was also celebrated which links this to the Maori cultural awareness of the service.

The service also initiated the concept of "white noise" which is used for a rest home level of care resident when unwell. This provides calming effect to the sick resident as well as it serves like a companion to the resident when alone in the room. It promotes good sleep which facilitates faster recovery of the rest home level of care resident.

The service is able to show significant quality improvements that are aimed at improving the activities of the residents in the different units. Residents and families confirm a high level of satisfaction with the service with this reflected in the satisfaction surveys and interviews during the day of the audit. There is also a robust recreation/activities internal audit as evidence in the documentation.

The service has been given a rating of continuous improvement in recognition of the activities programme and quality initiatives that are over and above the requirements in the standards.

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: CI**Evidence:**

The 10 out of 10 person centred care plans are evaluated six monthly and updated when clinically indicated as sighted in the documentation. Short term care plans are evaluated and resolutions of the problems are documented in the short term care plans and in the resident's progress notes. The degree of achievement or response to the intervention is clearly documented in the short term care plans and in the resident's progress notes. The treatment regimens are changed or modified when the resident's response to treatment is different from expected as sighted in short term care plans. There is a documented monthly and three monthly GP review depending on the complexity and level of care of the resident. There is a multi-disciplinary review (MDR) approach to the review of the PCCP that occurs every six months. The resident and family when available are invited to attend the MDR meeting for discussion. Families who are not able to attend are provided with a copy of the MDR outcome.

The resident's involvements in the planned activities are evaluated six monthly as sighted in the documentation. The activities coordinator and diversional therapist report that the evaluations are opportunities to explore other possible activities which are interesting and stimulating for the residents. The RNs are informed when the resident is not participating in activities in order to further evaluate the resident's mobility, cognition, pain, depression, and other interests in life.

The service initiated a clinical practice reflection called general file review. This is a more focused evaluation of a resident who manifests changes in behaviour, eating habits, participation in activities, increased confusion and other observations that might potentially lead to a resident's health deterioration. This includes the current diagnosis, medications, past/present risk assessments, vital signs, laboratory findings, medical notes and documentations from the resident's progress notes/allied health team inputs. Relevant informations are taken into consideration to identify the potential factors leading to the current condition. There are sighted clinical practice reflection completed for challenging behaviour, weight loss and falls.

The clinical manager and the business and care manager conducted this first reflective practice in 2013. The process begins with identifying the problem, reviewing the resident's file to find documentations relating to the problem, meeting the staff to discuss the resident's identified problem and finding a better intervention to resolve the problem in hand. The relatives and the resident when able are contacted and encouraged to attend the reflective practice review as confirmed by the three interviewed relatives. This is a more thorough review of the resident and the file in addition to the short term and person centred care plans (PCCP) in place. The MDR remains being conducted annually or when necessary while the PCCP remains being evaluated every six months.

The registered nurses are now confident and able to conduct independent clinical practice reflection as sighted in the documentation. The four RNs interviewed confirm that they conduct general file review that provides a more focused evaluation of the current identified problem.

The service is able to show significant quality improvements that are aimed at ensuring the resident's condition is evaluated in a more in-depth approach that captures vital information's to resolve the identified problem.

The service has been given a rating of continuous improvement in recognition of the evaluation of the service delivered to the residents and quality initiatives that are over and above the requirements in the standards.

The District Health Board 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: CI

Evidence:

Finding:

The service initiated a clinical practice reflection called general file review. This is a more focused evaluation of a resident who manifests changes in behaviour, eating habits, participation in activities, increased confusion and other observations that might potentially lead to a resident's health deterioration. This includes the current diagnosis, medications, past/present risk assessments, vital signs, laboratory findings, medical notes and documentations from the resident's progress notes/allied health team inputs. Relevant informations are taken into consideration to identify the potential factors leading to the current condition. There are sighted clinical practice reflection completed for challenging behaviour, weight loss and falls.

The clinical manager and the business and care manager conducted this first reflective practice in 2013. The process begins with identifying the problem, reviewing the resident's file to find documentations relating to the problem, meeting the staff to discuss the resident's identified problem and finding a better intervention to resolve the problem in hand. The relatives and the resident when able are contacted and encouraged to attend the reflective practice review as confirmed by the three interviewed relatives. This is a more thorough review of the resident and the file in addition to the short term and person centred care plans (PCCP) in place. The MDR remains being conducted annually or when necessary while the PCCP remains being evaluated every six months.

The registered nurses are now confident and able to conduct independent clinical practice reflection as sighted in the documentation. The four RNs interviewed confirm that they conduct general file review that provides a more focused evaluation of the current identified problem.

The service is able to show significant quality improvements that are aimed at ensuring the resident's condition is evaluated in a more in-depth approach that captures vital information's to resolve the identified problem.

The service has been given a rating of continuous improvement in recognition of the evaluation of the service delivered to the residents and quality initiatives that are over and above the requirements in the standards.

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

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

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

Attainment and Risk: FA

Evidence:

The CM and RNs facilitate residents' access to other medical and non-medical services available for them. The CM confirms initiating referrals for continence, wounds, disability support for change in level of care, mental health/psychiatric services, podiatry, physiotherapy, speech language therapy and dietician. The GP initiates specialist referrals as sighted in the medical notes. A referral form is utilised by the CM for external referrals and previous referrals are evidence in the documentation including wound nurse, speech language therapist and mental health services. The CM and RNs verbalise that they only use verbal referral for the physiotherapist and the cook.

The change in the resident's level of care is initiated by the clinical manager. The families are informed by the CM when reassessments are completed as well as the outcomes.

The District Health Board requirements are met.

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

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

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

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

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

ARC D21 ARHSS D21

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>There is a policy that describes guidelines for transition, exit, discharge or transfer from services. The clinical manager (CM) reports that they utilise the yellow envelope to transfer residents to the public hospital and to receive residents back from the public hospital. The CM mentions that the resident's current PCCP and medication charts when a resident is transferred to another facility or when taken to the hospital for acute admissions. A copy of the resuscitation status is included in the discharge notes including the last GP notes, a copy of the relevant progress notes and other relevant documentations. Hospital discharge notes and plans are received on discharge from the hospital.</p> <p>The CM and the RNs confirm that risks are identified prior to a transfer or discharge of a resident. There is an open communication between the service, the GP, the resident and families if available.</p> <p>The District Health Board requirements are met.</p>

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The medicine management in the service is not consistently implemented that complies with the current legislative requirements and safe practice guidelines. Medicines for residents are received from the pharmacy in a packed medicine delivery system. The medicines are checked for accuracy against the resident's medication charts. A medicine reconciliation process occurs with new admissions and when the resident returns from a specialist or hospital admission. Medicines are stored in locked medicine cupboard and staff administering medications keeps the packs inside a locked medication trolley as sighted during the lunch time medication rounds. The three staff administering the lunch time medications in the rest home, hospital and dementia units are following the medication administration procedure. A weekly stocktake is conducted by two staff for the controlled drugs. Staff are transcribing medications including antibiotics as evidence in three out of 20 reviewed medication charts. This is an area for improvement in 1.3.12.6. There are four unsigned or not countersigned areas in the controlled drugs register. This is an area for improvement in 1.3.12.6. The residents receiving controlled drugs have appropriate pain assessments in their files. The fridge is monitored daily by the night staff as sighted in the fridge temperature monitoring sheet. There are sharps bin containers sighted in the medication room.

There are three out of 20 medication charts not reviewed three monthly by the GP. This is an area for improvement in 1.3.12.6. This is recorded on the medication charts. All prescriptions sighted contain the date, medicine name, dose and time of administration. All allergies are documented in the 20 out of 20 medication charts. There is a photo of each medicine is shown in the medication chart to guide staff administering the medicines. A current photo of the resident is sighted in all 20 sampled medication charts. All expired or unwanted medicines are kept in a locked cupboard and are sent back to the pharmacy via the pharmacy delivery staff. There are no expired medicines sighted in the medication room.

The CM and RNs verbalise that medications are not crushed in the service. The CM reports that there are two residents who self-administer inhalers. There are processes in place for self-administration. The medicine self-administration policy is sighted and the CM is able to discuss the self-administration procedure. The inhalers are kept inside a locked cupboard in the resident's room.

The medication competencies for all the 14 RNs and one health care assistant are current and evidence in the documentation.

The District Health Board requirements D1.1g, D19.2d are not met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Medicine management information is not consistently recorded to a level of detail, and communicated to the residents at a frequency and detail to comply with legislation and guidelines.

Finding:

There are 20 medications charts reviewed with the following findings;

- I. Three out of 20 reflect transcribing of medications by staff administering medications.
- II. Three out of 20 are not reviewed by the GP every three months.
- III. There are four areas either not signed or not countersigned in the controlled drugs register for XXXXXX.
- IV. There are four unsigned areas in the medication signing sheets. The RNs confirm that medications have been administered.

Corrective Action:

- I. All staff must not transcribe medications.
- II. GP must review all medication charts every three months or as required.
- III. Staff to follow policies and procedures in relation to controlled drugs.
- IV. All staff to sign in the medication administration signing sheets after administering medications.

Timeframe (days): 90 (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:

A resident's individual food, fluids and nutritional needs are met where this service is a component of service delivery. The Food Service Manual is sighted. The clinical manager (CM) or registered nurses on duty (RNs) admit new residents to the facility and complete a dietary requirement form, with a copy is given to the cook. The resident's food dislikes are written in the comments section including food allergies. The cook reports that they cook special meals for other nationalities.

The food handling certificates of all staff working in the kitchen are current. The service provides modified diet like gluten-free, moulie and diabetic. There are substitute meals written in the menu as sighted when the resident wants an alternative meal. The CM and RNs inform the cook when there are texture modifications in the resident's diet.

The four week rotating menu is reviewed by the dietician last March 2014 for winter menu while the summer menu is reviewed last September 2013. The served meals are suitable for aged care residents and the food presented during the audit is still as the current menu. Food temperatures are conducted daily as sighted in the food temperature monitoring as well as the fridge/freezer/chiller temperature monitoring. The fridges are clean and with intact rubber seals. The cook reports that the cooked meat's temperatures are recorded immediately after is removed from the oven and before being placed in the bain marie before the food is served. Special food and dietary requirements can be arranged by the cook and the meals are well presented. Meals sighted are appropriate for the elderly and serving size is adequate.

Staff are using clean technique in food preparation. They are wearing hair nets, kitchen gloves and aprons. The staff serving the lunch time meals are wearing hair nets.

The cook rotates canned goods and labels all cooked and opened foods in the chiller and fridge. All canned goods are dated and cooked foods in the chiller are all dated. The kitchen is clean and there are adequate food supplies in the pantry. The cook places order directly to the supplier and checks quantity and quality of delivered items. A cleaning schedule is conducted daily as sighted in the cleaning schedule signing sheet.

The monthly weight monitoring is evidence in 10 out of 10 reviewed resident's files and the weights are stable.

The District Health Board 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staffs receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

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

Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. Infection control policies state specific tasks and duties for which protective equipment is to be worn.

Staff have last received training around chemicals and Clean care in August 2014.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 14 January 2015). There have been no buildings modifications since the last audit however there are room refurbishments in progress with over 15 completed to date. There is a planned maintenance schedule implemented.

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

The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programmes two yearly and this is up to date having been completed in July/August 2014. A contracted company has checked all medical equipment in June 2014.

Interviews with seven of seven health care assistants, four registered nurses and the clinical manager confirmed there is adequate equipment and cupboards viewed indicate that there are plenty of supplies.

There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required. There are safe outside areas that is easy to access for residents and family members.

In the dementia unit, the lounge area is designed so that space and seating arrangements provide for individual and group activities and there are quiet and low stimulus areas that provide privacy when required. There is a safe and secure outside area that is easy to access with a newly designed courtyard that is interactive. It includes edible plants, bus stop and mail box. The use of a printed adhesive transfer has stopped residents congregating at the exit door in the dementia unit.

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

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

Communal toilet facilities have a system that indicates if it is engaged or vacant noting that these were put in for some communal toilets and showers on the day of the audit. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

Ten residents (six rest home and four hospital) and 11 family members (three rest home, four hospital and four dementia unit) interviewed report that there are sufficient toilets and showers.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

Equipment was sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff and the resident. Residents requiring use of a hoist were sighted on the day with staff supporting them in their rooms with sufficient space for all.

Rooms can be personalized with furnishings, photos and other personal adornments.

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

The District Health Board requirements are met.

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>The service has lounge/dining areas including lounges in the dementia unit (secure unit). The dementia unit has a kitchenette.</p> <p>All lounge areas are large with appropriate floor coverings. All areas are easily accessed by residents and staff.</p> <p>Residents are able to access areas for privacy if required.</p> <p>Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>The lounges are also accessible lounge which is used for activities and a specific area for the hairdresser.</p> <p>There is adequate space in the dementia unit to allow maximum freedom of movement while promoting safety for those that wander. The dementia unit is secure at all times.</p> <p>The District Health Board requirements are met.</p>
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Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

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

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

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

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Laundry is contracted out and there is a laundry staff member to fold and return clothing and stock linen cupboards.</p> <p>There are cleaners on duty seven days a week and the cleaners were observed to have the trolley in the room with them when cleaning and all had appropriately labelled containers. Ecolab products are used with training around use of products last provided in August 2014.</p> <p>Cleaning is monitored through the internal audit process with no issues identified in audits completed in 2014.</p> <p>Chemicals and cleaning cupboards are locked on the day of the audit.</p> <p>The District Health Board requirements are met.</p>

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

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

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

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

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

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

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>An evacuation plan was approved by the New Zealand Fire Service in 2007. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly with the last drill conducted in May 2014. The orientation programme includes fire and security training. Staff confirm their awareness of emergency procedures.</p> <p>There is always one staff member at least with a first aid certificate on duty – confirmed through review of the roster and confirmed by the business and care manager.</p> <p>All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. The gas mains have been connected with a gas hob in place in the kitchen. A back up battery for emergency lighting is in place and this is fully checked and run for two hours annually.</p>

An electronic call bell system utilises a pager system. There are call bells in all residents' rooms, residents' toilets, and communal areas including the hallways, dining room and hairdressing space. Call bell audits are routinely completed.

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

In the dementia unit, there are always at least two staff on duty and all have access to other staff in the rest home and hospital in the event of an emergency with call bells connecting.

The District Health Board 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.

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

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

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

ARC D15.2f ARHSS D15.2g

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.</p> <p>Extra lighting has been added to the hallways as part of the decrease in falls project with positive effects for residents. The use of adhesive transfers on some exit doors e.g. from the dementia unit and in the hospital and rest home areas that are close to road areas have added light to the exit areas.</p> <p>Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.</p> <p>The District Health Board requirements are met.</p>
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Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

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

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

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

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:

There is a restraint minimisation policy and procedures sighted and implemented. The restraint register is current with six residents using bedrails and four residents using a lap belt. Restraint assessments are completed and restraint consents are signed by the restraint coordinator, GP and family/resident. Risk management plans are sighted in three out of three PCCP's (restraint section) and three monthly evaluations are evidence. Restraint minimisation and safe practice is encouraged.

The clinical manager (CM) is the restraint coordinator and the restraint coordinator job description is sighted in the restraint folder. The restraint coordinator also conducts yearly restraint minimisation audit and the outcome for this year's restraint audit is all fully achieved. The restraint in-service trainings are last conducted by the restraint coordinator on July 2014. The contents of the in-service as sighted include definition of restraint, difference of restraint and enabler and other relevant information relevant to restraint.

The restraint committee conducts three monthly meetings and the last meeting was conducted last August 2014. Restraint is included in the monthly quality improvement meetings. Staff are informed who are the current residents on restraints and the interventions as documented in the PCCP. This is evidence in the minutes of the meetings in 2014.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

The service has a restraint approval committee who determines and approves the type of restraint to be used and the duration and frequency of restraint monitoring. The CM is the restraint coordinator who updates the restraint register regularly. The restraint committee conducts regular monthly meetings as sighted in the evidence.

The restraint minimisation policy and procedure is sighted and implemented by the service. Residents when on restraint are monitored using the restraint monitoring form. Staff complete the monitoring form as sighted in the three reviewed resident's files on restraints. The five interviewed health care assistants (HCAs) are able to demonstrate knowledge about the restraint approval process, the risk management for residents on bedrails and the difference between a restraint and an enabler. The five interviewed health care assistants verbalise that they contact the restraint coordinator when a restraint is deemed necessary for the resident.

Restraint in-service education is completed last July 2014. All staff have current restraint competencies as sighted in the restraint competency register.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The restraint coordinator ensures that rigorous assessment of the resident is undertaken in relation to the use of restraint. The restraint coordinator completes a restraint assessment prior commencing the use of any restraint for any resident. Risk management plans are developed as sighted in three out of three reviewed resident's files on restraint. All of the residents on restraint have on-going evaluations as sighted in the documentations. Alternative interventions are documented in the restraint assessment forms sighted.

The restraint coordinator verbalises that the residents and their families are involved in the discussion regarding restraint process. The purpose and reason of the restraint including risk management plans are presented to the families prior commencing the restraint.

The District Health Board requirements are met.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;

- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The service uses restraint safely. The bedrails are with padded covers when in use and are checked regularly as per annual equipment’s maintenance plan. The approved restraints for the residents are applied as a last resort, with the least amount of force. The decision to approve restraint for a resident is made following appropriate planning and preparation by the restraint coordinator and the restraint committee. The restraint committee meets every three months and the minutes of the meetings are sighted in the evidence. The last restraint meeting is held last August 2014.

The type of restraint, duration of use, frequency of monitoring and desired outcome are clearly stated in the restraint assessment and evaluation forms. The risk management plans are documented in three out of three reviewed resident’s person centred care plans. Monitoring forms are completed by all staff after each shift. The five staff interviewed are able to discuss why monitoring is important and the resident’s needs to be checked including hydration, comfort, continence, pain, position and nutrition.

A restraint register is current and is established to record sufficient information to provide an auditable record of restraint use including evaluation dates and the date when the restraint is not required.

The District Health Board requirements are met.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The restraint coordinator evaluates all restraints in use for the residents. Restraint evaluations are conducted three monthly as sighted in all six residents using bedrails and four residents using lap belts. All restraint evaluations for the 10 residents using restraints are sighted in the resident's files. The restraint risk management plans are updated when required as reported by the restraint coordinator. There are no restraint-related injuries reported by the restraint coordinator or by the five interviewed staff.

The District Health Board requirements are met.

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

(a) Future options to avoid the use of restraint;

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

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

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

Attainment and Risk: FA

Evidence:

The service demonstrates monitoring and quality review of the use of restraint. The restraint minimisation policy and procedures are reviewed last March 2013. Trends are established and included in the review process. Risk management plans are sighted in all 10 reviewed PCCPs (restraint section). The three monthly restraint evaluations are sighted in all 11 reviewed resident's files using bedrails. The restraint coordinator provides restraint in-service trainings for all staff and is last conducted on July 2014.

The District Health Board requirements are met

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

There are clear lines of accountability for infection control and prevention for the service. Infection control and prevention is integrated into the monthly quality meetings. The infection control programme is appropriate to the size and scope of the service. The clinical manager (CM) is the designated infection control nurse (ICN). The job description of the infection control nurse is signed as evidence in the staff file and in the infection control folder.

The five interviewed health care assistants (HCAs) and three registered nurses (RNs) are able to demonstrate good knowledge on preventing the spread of infection, breaking the chain of infection and had confirmed some of the infection control programme of the service. The five HCAs and three RNs also verbalise that they will take a sick leave when not able to attend their shift and when to inform management regarding signs/symptoms of an outbreak of infectious disease and they have access to infection control informations in the service.

Visitors, families and staff are reminded not to enter the service when not feeling well. There is a sign noted in the reception area of the service. A hand sanitiser is also sighted in the reception area. There are hand sanitisers in the corridors in the rest home, hospital and dementia units.

The infection control programme is last reviewed on February 2014 as sighted in the evidence.

The District Health Board requirement is met.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The clinical manager (CM) is the designated infection control nurse (ICN) who has access to the GP, laboratory and microbiologist. The business and care manager (BCM) provides assistance to the ICN. The infection control committee includes qualified health professionals with the relevant skills, expertise and resources necessary to achieve the infection control standards. There is a representative from the different areas within the service (care staff, nursing, maintenance, laundry, and kitchen). The last infection control committee meeting on July 2014 is evidence in the records.

There are infection control signages within the service to prevent the spread of infections. Hand gels are available and sufficiently distributed inside the facility.

The infection control nurse has access to relevant and current information's including internet, intranet, the Ministry of Health web pages, access to DHB experts and laboratory services. There is also an ongoing in-service education on infection control and prevention as sighted in the education programme of the service. The last in-service on January 2014 is sighted in the records. The infection control internal audit is last conducted on May 2014.

The infection control programme is last reviewed on February 2014.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has documented policies and procedures implemented for the prevention and control of infection that reflects good practice that meets relevant legislative requirements. These policies and procedures are practical, safe, and appropriate for the type of service provided.

The five interviewed health care assistants (HCAs) confirm that the policies and procedures are accessible to them when they need to read about certain topics. Infection control prevention and control is integrated in the orientation programme for all staff. The contents of the orientation for infection control prevention and control are comprehensive and practical. The staff added that the use of gloves needs to be single use and must not be worn in the corridors. The health care assistants also mention that the infection control nurse is available to them to clarify infection control issues or some procedural concerns regarding infection control.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The service provides relevant education on infection control prevention and control to all staff and residents. This is evident in the monthly staff and resident's meetings.

The five interviewed health care assistants (HCAs) confirm that there are in-service trainings on hand-washing, standard precautions, use of personal protective equipment's (PPE), antimicrobials, spread of infections and signs/symptoms of an infectious disease. The in-service in standard precautions and surveillance is held last January 2014. A record of this in-service is evidence in the education planner. The five interviewed health care assistants are also able to demonstrate good knowledge on infection control and prevention. Other suppliers for continence and wound products also provide in-service trainings for the staff as reported by the clinical manager.

Two residents verbalise that staff talk about the importance of hand washing to them especially before eating and after using the toilet. The two residents added that they are aware of the importance of hand washing as constantly emphasised by the RNs and the clinical manager.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:**Finding:****Corrective Action:**

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The surveillance for infection rate is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. The infection control surveillance is appropriate to the size of the service. Infection rates are monthly monitored and collated by the infection control nurse with the guidance of the clinical manager including urinary tract infections, skin, wound, respiratory tract infections, gastro-intestinal tract infections and ears/ear infections. These infections are entered in the intranet system for benchmarking with other services within the organisation. Infection rates are discussed during the monthly quality meeting as sighted in the quality meeting folder. The interventions to reduce, manage and prevent the infections are discussed during monthly quality improvement meetings as evidence in the records.

The results of the monthly infection surveillance are sighted in the intranet and in the monthly quality improvement meetings.

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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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 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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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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