# Oceania Care Company Limited - Whitianga Continuing Care

## Current Status: 11 August 2014

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

## General overview

Whitianga Continuing Care was part of the Oceania Group and provided rest home and hospital care. Occupancy on the day of the audit was at 51 with 28 residents in the hospital and 23 residents who required rest home level care.

The service has continued to maintain a comprehensive quality and risk management programme that included management of complaints, incidents, accidents, hazards with a robust health and safety programme in place. The service was managed by an experienced business and care manager/registered nurse who had been in the position for four months. The business and care manager was supported by a clinical leader who provided oversight of the clinical care services. Residents stated that there was good communication and complaints were managed in a timely manner.

A well-developed staff orientation and education programme was implemented and staffing is being reviewed to align with the needs of residents and the staffing policy. There was at least one registered nurse on duty at all times.

The improvement required at the previous audit around wheelchair access in and out of the building has been addressed.

There are no improvements required at this audit.

## Audit Summary as at 11 August 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 11 August 2014

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

### Organisational Management as at 11 August 2014

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

### Continuum of Service Delivery as at 11 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. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 11 August 2014

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

### Restraint Minimisation and Safe Practice as at 11 August 2014

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

### Infection Prevention and Control as at 11 August 2014

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

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Oceania Care Company Limited |
| **Certificate name:** | Oceania Care Company Limited - Whitianga Continuing Care |

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

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Whitianga Continuing Care |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 11 August 2014 | **End date:** | 11 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:** | 53 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX  | **Hours on site** | 8 | **Hours off site** | 4 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **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** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 10 | Total audit hours | 26 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 10 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 63 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, Managing Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health Audit (NZ) Limited | Yes |
| b) | Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health Audit (NZ) Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | Health Audit (NZ) Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health Audit (NZ) Limited has finished editing the document. | Yes |

Dated Thursday, 24 April 2014

## **Executive Summary of Audit**

**General Overview**

Whitianga Continuing Care was part of the Oceania Group and provided rest home and hospital care. Occupancy on the day of the audit was at 51 with 28 residents in the hospital and 23 residents who required rest home level care.

The service has continued to maintain a comprehensive quality and risk management programme that included management of complaints, incidents, accidents, hazards with a robust health and safety programme in place. The service was managed by an experienced business and care manager/registered nurse who had been in the position for four months. The business and care manager was supported by a clinical leader who provided oversight of the clinical care services. Residents stated that there was good communication and complaints were managed in a timely manner.

A well-developed staff orientation and education programme was implemented and staffing is being reviewed to align with the needs of residents and the staffing policy. There was at least one registered nurse on duty at all times.

The improvement required at the previous audit around wheelchair access in and out of the building has been addressed.

There are no improvements required at this audit.

**Outcome 1.1: Consumer Rights**

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family. Staff ensure residents are informed and describe how residents have choices related to the care they receive. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

**Outcome 1.2: Organisational Management**

Services are planned, coordinated, and are appropriate to the needs of the residents. Day-to-day operations are being managed efficiently and effectively with the business and care manager and clinical leader providing operational and clinical oversight respectively. This ensures the provision of timely, appropriate and safe services to the residents. Quality and risk management processes are documented and maintained, reflecting the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and are reported to those affected in an open manner.

Human resources processes are managed in accordance with good employment practice. Education and training needs are being met by the organisation. Residents receive appropriate services from suitably qualified staff.

**Outcome 1.3: Continuum of Service Delivery**

The residents, family, staff and a general practitioner interviewed express a high level of satisfaction with the quality of care and services provided at this service. The service provides rest home and hospital level care, which is clearly and accurately identified in the pre-admission information. Services are provided by suitably qualified and trained staff to meet the needs of the residents. Residents have an initial nursing assessment and care plan developed and implemented for the first three weeks after admission. A person centred care plan was clearly documented by a registered nurse and reviews occurred six monthly or more often if and when required. Residents are reviewed by the general practitioner regularly to respond to any changing needs of the resident. The multidisciplinary team has input when the reviews occur.

The provision of services is maintained to meet the individual needs of residents. A team approach was provided and staff interviewed ensured the continuity of service delivery. The service has a planned activities programme to meet the recreational needs of the residents. Residents are encouraged to have links with family/whanau and the community. The residents and family interviewed expressed high satisfaction with the individual activities offered at this residential care service.

A safe and timely medication system was observed. The service has documented evidence that staff responsible for medication management are assessed as being competent. The medication records have been reviewed by the GPs three monthly. The controlled drug medication process is managed effectively and legislative requirements are met.

The meal service is well managed and the two cooks employed are both very experienced. The winter menu plans have been reviewed by the organisation`s dietitian. Special diets and foods can be arranged to meet the individual needs of the residents. Likes and dislikes are always considered. Nutritional status assessments are performed on all residents on admission to this service. The dietitian is available for consultations and advice if required.

**Outcome 1.4: Safe and Appropriate Environment**

Whitianga Continuing Care holds a current building warrant of fitness. There is a planned maintenance schedule implemented with evidence that the facility is maintained.

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

There are clear policies and procedures for the use of enablers. No restraints and/or enablers are currently in use at this facility. The staff interviewed are well informed and have received education on restraint/enablers and restraint minimisation and safe practice.

**Outcome 3: Infection Prevention and Control**

The service has infection prevention and control policies and procedures relevant to the level of care provided. The surveillance programme is adequate for the size and nature of this aged care residential service. The registered nurse interviewed was very experienced and had recently undertaken this additional role. Education was provided to all staff at orientation and is on-going. Surveillance management was well documented and any information was fed directly back to staff after all data was analysed and comparisons made from previous months.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

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

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

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An open disclosure policy and procedures is in place. The open disclosure policy identifies the services committed to the provision of safe, quality health care to the residents and community it serves.

The business and care manager operates an open door system as confirmed by resident and family interviews.

Family confirm they are kept informed of any concerns or changes to their relative's care. This is clearly shown on incident and accident forms sighted (19 reviewed) and as documented on communication notes in resident files (five files reviewed including two rest home and three hospital). All resident files reviewed evidence communication to the resident’s family about any significant changes to the resident.

There are quiet spaces in the hospital and rest home areas including a large lounge/dining area, a separate dining area that is smaller and a number of small rooms for people to hold quiet conversations. There is a library that can be used for meetings and family group.

Interpreter policies and procedures detailing access to interpreting services is available. Interpreters are usually accessed through the DHB if required. There are no residents currently requiring the use of an interpreter and the business and care manager states that there have been no interpreters required since the last audit.

Eight residents (five hospital and three rest home) and three family members (two hospital and one rest home) interviewed state that staff have sufficient time for discussions, appropriate space for discussion is available and that they are given time to talk about the care they are receiving.

Information is given to the resident and/or family in a timely manner as confirmed in interviews with eight of eight residents and three of three family members. Residents or nominated next of kin sign the resident agreement on the day of entry as sighted in five of five files reviewed.

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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisation has a comprehensive complaints process in place. It complies with Right 10 of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

All complaints are reviewed at management level by the business and care manager and the clinical leader as relevant.

The business and care manager has an open door policy and both the business and care manager and the clinical leader are visible so that residents and family feel comfortable to discuss any concerns, issues or complaints at any time.

Complaints forms are accessible for anyone requiring these at the entrance. The business and care manager received a complaint on the day of the audit and it was immediately entered onto the complaints register.

There is a complaints register and a review of two complaints indicate that these are resolved according to timeframes outlined in the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and policy. The restraint register summarizes the complaint category (communication, care/treatment, environment, consumer rights, hotel services and miscellaneous. There is a complaint summary, resolution, date, reviewed/audited and resolved.

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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 service provided aligns with requirements of the service agreement and relevant law i.e. there is comprehensive insurance cover for the business.
The philosophy is 'It doesn’t matter where you work or what you do, you are always expected to live the Oceania values of respect, excellence, passion and delivery and speak out when you feel these values are being compromised'.

There is a business strategy and quality plan for 2014 (sighted) with goals and targets including service delivery, occupancy, staff and HR, quality reviews and projects, business and financial. The business and care manager completes a business status report monthly and this informs the executive management team of financial performance, revenue, healthy workplace, services and choice, resident connect, family connect, relationships and market presence, competitive analysis, physical products.

Whitianga Continuing Care is certified for 53 beds of which 51 are occupied – 23 rest home (with 16 designated as for rest home only) and 28 hospital residents’ beds inclusive of three general practitioner beds (one occupied on the day of the audit.)

The business and care manager is a registered nurse and has worked previously in the prison service, District Health Board with three years previous experience as a business and care manager (a total of four years in aged care). An interview with the business and care manager shows attendance at appropriate education / training sessions and a current practising certificate with the appointment to the role being in April 2014. Staff interviewed confirm that the business and care manager is available after hours and all residents and family interviewed know the business and care manager and confirm that they are welcomed and would complain if need be.

The clinical leader has previous experience as a practice nurse for 16 years and has been a registered nurse and clinical leader for 10 years in the service. Both the clinical leader and business and care manager are on call.

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has Oceania policies and procedures and associated implementation systems to provide a level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. Interviews with three health care assistants, a registered nurse, an enrolled nurse, the clinical leader and the business and care manager confirm that new or reviewed policies are discussed at meetings and confirm that this is a successful method for communicating changes to policy. Staff sign to confirm that they have read and understood any policies that are new or reviewed.

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. There is a clinical indicator report monthly and benchmarking occurs with other like facilities.

There is a quality and risk management programme being implemented at Whitianga Continuing Care that includes an implemented internal audit programme. Audit summaries and action plans are completed where a noncompliance is identified with evidence of resolution of issues. The programme includes review of incidents, accidents, complaints, health and safety and surveillance of infections, pressure injuries, soft tissue/wounds. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and management of this population appropriately as per care planning.

Resident/relative satisfaction surveys are completed annually with positive feedback provided in the 2013 and 2014 surveys. Actions are identified and followed through as required.

Monthly meetings are in place that include health and safety, management/quality improvement, registered nurse and general staff meetings. Representatives of all areas such as housekeeping and maintenance attend the management and quality improvement meeting. All aspects of the quality and risk management programme are reported through all meetings including review of incidents and accidents, complaints, internal audit reports. Staff ensure that they read all minutes.

Key improvements in the service have been around a reburbishment of the facility and a continued review of staffing levels. Data and review of each quality improvement project shows that there have been improvements made to the service.

The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service collects incident and accident data. The incident/accident form provides an account of the incident; what actions were taken in response; who and when people were informed; any detail that will assist in determining how the incident occurred; and what actions were taken/are required to prevent recurrence. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required.
Nineteen incident forms reviewed across the service demonstrated relevant follow-up.

Discussions with the business and care manager confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications.

Three of three family members interviewed state that they are always informed of incidents and 19 of 19 incident forms reviewed indicate that family are informed appropriately.

The District Health Board 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:**

Current annual practising certificates for the clinical leader, registered nurses and enrolled nurse are sighted. Practising certificates are also available on-site for the podiatrist, pharmacist, community occupational therapist, dietitian and general practitioners.

Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files selected for review show that all staff files audited include up-to-date performance appraisals completed annually for staff.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. registered nurse, support staff, kitchen staff) and includes documented competencies. New staff are buddied with an experienced health care assistant during their induction programme as confirmed by a health care assistant who has been in the service for three weeks. Completed orientation checklists are documented on eight of eight staff files with training records also sighted. Staff interviewed are able to describe the orientation process and report that new staff are adequately orientated to the service.

Discussions with staff and management confirm that an in-service training programme is in place. Staff hold current first aid certificates and the business and care manager confirms that there is always a staff member on site with a first aid certificate.

A competency programme is in place with evidence of annual medication competencies for the registered nurses, enrolled nurses and senior health care assistants with these sighted on the relevant files reviewed. A spreadsheet of all completed competencies is maintained indicating that all staff have completed annual relevant competencies.

The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a safe staffing policy that aligns with contractual requirements and includes skill mixes. The service reviewed the staffing numbers in November 2013 and is in the process of reviewing staffing currently to ensure that it aligns with policy. This will adjust hours of some staff e.g. to start the kitchen assistant later in the morning when needed.

There are a total of 63 staff including 11 registered nurses, three enrolled nurses, activities coordinator from 10am-4.30pm Monday to Friday, two cleaners seven days a week at least, laundry seven days a week, a cook seven days a week with kitchen assistants to support the cook and 39 health care assistant including 14 casual staff. The area does not have bureau staff and relies on causal staff to cover leave.

A physiotherapist is contracted in when required and there is a physiotherapist assistant on site for 28 hours a week from Monday to Friday.
The sighted rosters in 2014 indicate that staff are replaced when on leave.

Staffing is appropriate to the needs of the residents with two health care assistants full shift overnight, a registered nurse on each shift and an enrolled nurse on the morning and afternoon shifts. Staff are replaced if on leave as sighted in past rosters reviewed. Family members and residents state that there are sufficient staff on all shifts noting that two are concerned that the decrease of one health care assistant on the afternoon shift may impact on care. The business and care manager states that this will be monitored.

The District Health Board 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):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The five of five care person centred care plans (three hospital and two rest home) reviewed are current and up to date. The documentation takes into consideration the Needs assessment co-ordinator`s service (NASC) assessment prior to admission and subsequently the comprehensive assessment performed by the clinical Leader or the registered nurses on admission to the service.

The clinical leader, the 11 registered nurses and three enrolled nurses all have approved and verified annual practising certificates. The general practitioners, the physiotherapist and podiatrist also have their individual annual practising certificates reviewed annually. The clinical leader maintains a record which is updated annually.

On admission all residents have an initial care plan which is developed and implemented to guide the staff within the timeframe of the first three weeks. After this period the person centred long term care plan is developed by the registered nurse. Recognised assessment tools are utilised and re-evaluations occur on a regular basis to ensure interventions are appropriate and that goals can be effectively met.

The staff, inclusive of the healthcare assistants, the cook, enrolled nurses, physiotherapist-aid and the activities co-ordinator all have significant input into the review of each individual care plan during the review process. Reviews occur six monthly or more often if required. Three health care assistants, one enrolled nurse and one registered nurse at interview verified that team work is encouraged and that continuity of care is provided. This is reflected in the five person centre care plans and daily progress records reviewed.

The GP at interview states that the GP practice and doctors concerned cover this aged care service and the community twenty four hours a day seven days a week. The doctors at this practice has covered this aged care service since it commenced. The practice is in close proximity to this service. The medical records are well maintained and an entry is made at each contact with the residents. Ongoing education is planned for this service for 2014 – 2015 and is available and accessible to staff. Three healthcare assistants, one registered nurse and one enrolled nurse at interview verify their participation in the education programme and are skilled to care for the residents.

The district health board contract requirements are met.

Tracer Methodology: Rest Home

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

Tracer Methodology: Hospital

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

The resident`s family interviewed is very pleased with the holistic care and management provided by all staff.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The five of five person centred care plans reviewed record interventions that are consistent with the residents` assessed needs and desired outcomes/goals. Observations on the day of audit indicate residents receiving care that is consistent with the residents` needs. Short term care plans also highlight the problem identified, the intervention required, signature and date evaluated. The five of five residents and the five of five family interviews report that the service needs of the resident are met. The one enrolled nurse, one registered nurse and three health care assistants interviewed report that the care plans are accurate, up-to-date and do reflect the individual resident`s needs.

The district health board contract requirements are met.

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.3.7: Planned Activities **(**HDS(C)S.2008:1.3.7)

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

**Attainment and Risk:** FA

**Evidence:**

Policy is in place for the activity planning and processes involve to guide staff. Information regarding each resident`s activity needs and choices is gathered on admission and regularly thereafter. Relevant information is shared as applicable with members of the multi-disciplinary team. Documentation of the family history, social history and life story identifies how the activities co-ordinator gains an understanding of each resident prior to developing and implementing the individual activities plans which has identified goals, intervention, expected outcomes and is signed off by the resident/family/whanau and dated.

The activities co-ordinator at interview has been in this role for 10 years. The activities co-ordinator explained the position and the objectives of the activities programme developed and implemented. In the front of each residents activities plan it states clearly `that every resident at Whitianga Continuing Care Unit has the opportunity and is either encouraged, supported, involved in or given the right to decline activities`.

The programme is planned and developed monthly and displayed on a weekly basis. The activities programme is flexible and varied in content and meets the needs of the residents at this facility. The environment is homely and activities of normal life are encouraged. On observation residents are seen to be enthusiastically making pikelets and later were seen to be eating them for afternoon tea. Outing into the community are encouraged and a van outing is planned every Thursday. A van outing register is also maintained by the activities co-ordinator. There is a designated driver (current licence verified) and volunteers assist as required. The activities co-ordinator has a current first aid certificate and there is a first aid box located in the van. The van utilised is a six seater (for six residents) or alternatively can carry two residents in wheelchairs and four residents.

The five of five activity plans reviewed do consider activities, skills and potential capabilities, needs, limitations and precautions (if any), interests and roles including family, friends, self, community and cultural requirements. Each individual resident`s activity plan is evaluated six monthly at the time the care plan is reviewed and is signed off appropriately by the activities co-ordinator performing the evaluation. A recreational activities sheet is used to record attendance of activities provided.

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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.3.8: Evaluation  **(**HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

**Attainment and Risk:** FA

**Evidence:**

Nursing reviews and assessments, medical and any specialist consultations and admission/transfer summaries are clearly documented in the five of five resident`s records reviewed. Documentation reflects the evaluations of the individualised care plans are conducted six monthly and more often if and when required. Interventions are changed to ensure all needs and goals set can be effectively met.

If a resident is not responding to the service interventions being delivered, or a residents health status changes, then this is discussed with the relevant general practitioner (GP) or the GP on call for the service. The GP at interview validated this information. Short term care plans are sighted for any significant changes in mobility, wound care, infections, changes in food and fluid intake and/or skin care. These processes are clearly documented on the short term car plan, medical and nursing and the resident`s progress notes.

The multidisciplinary reviews are completed and information is available and reviews are sighted in the resident`s records. Five of five resident reviews confirm their input as able into the reviews. Three family interviews confirm family input is sought. The clinical leader and the one registered nurse interviews verifies that family are able to consult with them anytime and if they have any concerns an appointment can be arranged with the GP concerned or the family can attend in person when the doctor is visiting the facility on arranged days.

One of the GPs from the community practice contracted to this service visits the facility every day of the week Monday to Friday. If progress is different than expected the family is always notified and this information is provided or communicated to the family as soon as possible. This is clearly documented in the progress records and on the family communication page sighted. Handover of staff was observed and all relative information is handed over between each shift inclusive of any issues to be highlighted, incidents or information about residents that are unwell or if the GP has been contacted.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has appropriate policies and procedures in place to reflect safe and timely medicine management. Procedures comply with current legislative requirements. The GP available for interview ensures reconciliation of all medications occurs with the contracted pharmacist on a regular basis. The medication records are reviewed by the GPs three monthly and the medication records reviewed 10 of 10 evidence this has occurred. Photo identification is sighted on all individual residents medication records sighted. Any allergies or sensitivities are clearly documented and alert stickers are used. Duplication name stickers are also used as required. Should a resident be on XXXX and or XXXX they have also have a separate administration and signing record sheet for this and records of the INR and blood glucose results are available.

The clinical leader and the 10 registered nurses are all trained in medication management and have completed medication competencies. The lunchtime medication round is observed in progress. The registered nurse has a blue apron to wear to signify that she is administering the medications. There is a policy in place for residents self-medicating under supervision to guide staff. A self-medicating assessment tool form is used and when completed is signed off by the resident, clinical leader and the GP concerned. Currently three residents are self-administering medications. One resident has a medication to take daily and the other two residents are able to use their inhalers as needed.

The blister pack medication is dispensed from the contracted pharmacy and signed by the pharmacist. When delivered to the facility the registered nurses check the packs individually. If there are any errors or concerns the pharmacist is notified. The blister-pack system works effectively as reported by the GP, the clinical leader and the one registered nurse interviewed.

The medications are stored safely in a locked cupboard and in the trollies (2) provided and utilised for the medication rounds. The two medication trollies are stored in the locked medication/treatment room when not in use. The controlled drugs are stored in a locked cupboard. The controlled drug book is dated and the contents pages are clearly documented. The clinical leader and one registered nurse or two registered nurses check the controlled drugs weekly on Wednesdays. Entries and balances are documented in red pen. The pharmacy audit and stocktake was performed March 2014 by the pharmacist. The registered nurses are responsible for the ordering of all medications.

The registered nurses attend relevant study days as per the education programme 2014 - 2015 and maintain records in their individual portfolios for the New Zealand Nursing Council and in their personal files reviewed.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The food service preparation is undertaken within appropriate areas using appropriate staff and equipment. The rubbish is collected weekly by the local council rubbish collections and recycling services. The kitchen is large and is clean and well presented. Clean and dirty flow observed for dishes and food preparation. The dining room is adjoined to the kitchen which is very spacious and residents in wheelchairs can be easily accommodated at meal times. The food is monitored by the cook interviewed prior to serving. Temperatures recorded evidence food temperatures are well maintained within normal limits. The cook is very experienced and job shares with another cook. All kitchen staff have completed safe food handling courses and the cook interviewed is fully aware and informed about infection control protocol. A kitchen hand is on each shift to assist the cook 8.30am – 5.30pm and an evening kitchen hand is available from 2.30pm until 8.30pm.

The menu plan for winter has been reviewed by the organisation`s dietitian and a letter is available dated 11 March 2014 verifies this has occurred. The annual practising certificate for the dietitian is available for 2014-2015 expiry 31 March 2015. Special days are celebrated (eg, Birthdays, anniversaries, Easter, Christmas and others. Special diets are arranged such as gluten free, increased protein, low fat, increase weight, decrease weight and diabetic diets as required. A whiteboard in the kitchen highlights likes/dislikes and special requirements for individual residents and their needs are met. The menu is visible for all residents and the daily menu is displayed.

The cooks is responsible for the ordering of all food, checking supplies on arrival when delivered and the rotation of foods that are stored, such as dry stock. Stores sighted are appropriate should an emergency occur. This is important due to the geographical location of this facility should an emergency occur as access may be difficult. Food temperatures and fridge/freezer are closely monitored daily. Records sighted are within the normal range. Cleaning schedules and daily tasks are displayed and achieved by the kitchen hands daily. Chemicals are stored effectively and are well labelled. Material data sheets are located in a container wall mounted next to the dishwasher.

Residents five of five state that they enjoy the meals provided and family three of three commented that presentation of food served is excellent and enjoyed by residents. Food service surveys are performed annually as part of the service survey to residents/family/whanau and feedback process.

The district health board contract requirements are met.

##### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 3 September 2014). There have been no buildings modifications since the last audit however there are room refurbishments in progress. 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. BV Medical have checked all medical equipment in February 2014. Interviews with three of three health care assistants, the registered nurse, enrolled nurse and the clinical leader 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.

The service has put wedges onto door lips to make it easier to get wheelchairs through the doors. One family member particularly asked states that this has made it easier to negotiate a wheelchair. The previous improvement required at certification has been addressed.

The District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

# 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 are policies and procedures in place to ensure any restraint use is actively minimised. Policy defines enablers are voluntarily used by a resident following appropriate assessment. The policies and procedures available were reviewed March 2013. There are no residents currently using enablers. When an enabler is used consent will be sought and considered. The restraint/enabler register is up to date and verifies the name of the resident, date of birth, date the enabler commenced, type of enabler used and the evaluations which occur. Interviews with the registered nurse who is now the restraint co-ordinator demonstrates knowledge and understanding of the definition of an enabler and processes to be followed should a restraint be used. Staff education is provided as part of the orientation/induction process. A workbook is completed by all staff on restraint minimisation safe practice annually.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Results of surveillance are acted upon, evaluated and reported to relevant personal in a timely manner. Surveillance monitoring is the responsibility of the infection control co-ordinator (ICC), the registered nurse clinical leader appointed to this role. This includes an audit of the facility next due May 2014, hand hygiene and surveillance of infection control events and infections. The infection control co-ordinator is responsible to the business and care manager. There is an infection prevention and control register sighted in which all infections are documented monthly. Infections treated or untreated are clearly documented on the infection control register (this was an area of required improvement in the previous audit). The infection control committee consists of the ICC, a cleaner, a rest home hospital care assistant, one activities/physiotherapist aide, a hospital health care assistant, and a laundry staff member when available. Meetings occur two monthly and minutes of the meetings sighted are maintained (this is an area of required improvement from the previous audit).

Surveillance covers respiratory, urinary, skin, eye, ear, mouth and wound infections. A monthly infection report is completed and a comparative summary is completed of all facilities in the organisation as part of the benchmarking programme. Graphs are provided in diagrammatic form with summaries and are sent back to the facility from head office and the three areas, rest home, hospital and dementia unit are clearly documented in relation to surveillance. No trends or outbreaks of infection have occurred or been identified since the last audit. The infection control report inclusive of surveillance performed is collated by the infection control co-ordinator and is reported to the business and care manager. Infection control is closely linked to the health and safety and to the quality and risk management system for this service.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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