

Oceania Care Company Limited - Addington Lifestyle Care

Current Status: 6 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

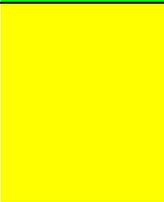
Addington Lifestyle Care provides residential care for up to 97 residents who require hospital, rest home and dementia level of care. The occupancy on the days of the audit was 97 residents; 29 rest home, 28 dementia and 40 hospital residents. The facility is operated by the Oceania Care Company Limited. The residents and family interviewed provided positive feedback on the care services at the facility.

There were areas identified as requiring improvement during this audit relating to the complaints processes, corrective action plans, informed consent, short term care plans and the medication management system.

Audit Summary as at 6 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 6 August 2014

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

Organisational Management as at 6 August 2014

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

Continuum of Service Delivery as at 6 August 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--	--	--

Safe and Appropriate Environment as at 6 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 6 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 6 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.
---	--	--

Audit Results as at 6 August 2014

Consumer Rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the facility's complaints process and the Nationwide Health and Disability Advocacy Service information is accessible at the facility and provided to residents and their families on admission to the facility. The residents' individual privacy and dignity needs are assessed on admission. The residents' privacy is maintained and personal belongings are treated with respect. The residents and the family members interviewed confirm that their rights are met.

There is a documented Maori health plan which acknowledges the principles of the Treaty of Waitangi and is aimed at reducing barriers to access.

Written and verbal consent is gained where and when required. The residents are supported to maintain links with their family and the community.

The business and care manager is responsible for the management of complaints and a complaints register is maintained.

There are areas identified as requiring improvement around the informed consent and the complaint processes.

Organisational Management

The Oceania Care Company Limited is the governing body and is responsible for the services provided at Addington Lifestyle Care. The services are appropriate and planned to meet the needs of the residents assessed as requiring rest home, hospital and dementia levels of care.

The organisation has a documented quality and risk management system in place. The required policies, procedures and work instructions are in place and accessible. There are systems in place for monitoring the services provided at Addington Lifestyle Care including regular monthly reporting by the business and care manager and the clinical manager to the Oceania support office. An internal audit programme is documented, however improvements are required to the consistency with which corrective action plans address all identified shortfalls are developed, implemented, monitored and signed off as being completed.

The risks are identified and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risks.

The facility is managed by a suitably qualified and experienced business and care manager, who is a registered nurse. The business and care manager is supported by a clinical manager who is a registered nurse and who is responsible for oversight of clinical care provided.

Adverse events are documented on an accident/incident forms, as well as on an electronic database that is able to be reviewed by personnel in Oceania head office. The essential notifications are made where required. The adverse events are managed in an open and transparent manner. The collated adverse event data is communicated to staff.

The human resource management system is conducted in line with good employment practice. Prospective staff are screened and qualifications validated. All staff have a documented role description which outlines their key accountabilities and functions. The orientation and induction process ensures staff are aware of the essential components of service delivery at the facility. The validation of current annual practicing certificates for staff who require them to practise is occurring.

An in-service education is provided for staff and staff are supported to complete the New Zealand Qualifications Authority Unit Standards via the Oceania certificate in residential care. The planned education / training programme is implemented. Staff performance is monitored through the completion of defined competencies and annual performance appraisals. A review of staff records provide evidence that human resource processes are followed, orientation for new staff are completed and individual staff education records are maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The staff interviewed report there is adequate staff available and that they are able to get through their work. Staffing is appropriate to meet the needs of residents, with experienced advice and assistance available.

The resident information is entered into a register in an accurate and timely manner. The resident information is maintained in a hard copy integrated file. The information is appropriate in detail to the type of facility, is uniquely identifiable and kept current. Residents' personal information is secure and not publically accessible/observable. Records of past residents are maintained and archived off site.

Continuum of Service Delivery

The admission agreement defines scope of service. The clinical manager confirms access and entry processes are followed. The service has an admission pack available for resident and their family who are new to the facility. Residents will only be declined entry if not within the scope of the service or if there is no bed available at the time of the enquiry. Residents who are declined to the service are informed of the reasons for decline of entry.

The service ensures continuity of service delivery through handover at the end of each shift, progress notes and entries to diaries and other records. Residents and family members are involved in the different stages of service provision. Residents' care plans are developed by the registered nurses and signed by family or the resident. Residents' risk assessments are completed on admission and the care plans include goals, interventions, assessments and six monthly reviews. Documentation and observations made of the provision of services and/or interventions, demonstrate that consultation and liaison is occurring with other services. Care plan evaluations are documented resident focused. There is a requirement for improvement relating to the service having to implement changes to the care plans when the resident's care needs change. The resident files sampled evidence referral forms and letters to nursing, allied health and medical specialists.

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

Medication rounds were observed in the dementia unit and in the hospital. The general practitioner signs and dates all entries to the medicines charts, allergies are recorded, each chart has resident's photo identification, and discontinued medicines are signed, crossed out and dated. There are two residents who self-administer medicines. All staff members who administer medicines complete annual competency testing.

The controlled drugs are stored securely. The controlled drug entries into the drug registers are checked weekly by registered nurses and the pharmacy does a six monthly drug stock-take of controlled drugs. The service monitors the medicines fridge temperatures daily. The service has a process for returning expired medicines to the pharmacy. There is a requirement for improvement relating to the general practitioner not consistently reviewing the medicines charts at three monthly intervals.

The food, fluid and nutritional needs of residents are provided in line with recognised guidelines that are appropriate to the residents' needs. The menus are reviewed annually by the dietitian from the Oceania support office.

Safe and Appropriate Environment

There have not been any alterations undertaken to the building since the last audit although extensive refurbishment has occurred. There is a current building warrant of fitness. The facility is a single level building and accommodates all kitchen and laundry services.

All residents' bedrooms have full en-suites, except two rooms that share an en-suite. The residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids, as well as staff. The residents are provided with adequate and accessible areas for relaxation, activities and dining. There are lounges and sitting areas throughout the facility, as well as dining areas in each area of the facility.

There are safe and accessible external areas and well maintained paths and gardens. The external areas and gardens are available for sitting and shade is provided. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. The staff receive training in safe and appropriate handling of waste and hazardous substances. There are sluice facilities, safe storage of chemicals and equipment, and protective equipment and clothing provided and used by staff.

Review of documentation and visual observation provide evidence there are appropriate systems in place to ensure the residents' physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site. The cleaning and laundry systems include appropriate monitoring to evaluate the effectiveness of these services.

There are documented processes for the management of all emergency and security situations. All staff receive training in emergency management and first aid. There is an approved fire evacuation plan and fire drills are conducted six monthly. The service has planned for civil defence emergencies and has alternative energy and utility sources available if required.

The service endeavours to maintain the facility at the constantly comfortable temperature. There is adequate heating and ventilation.

Restraint Minimisation and Safe Practice

The service actively works towards minimising restraint. The responsibility for the restraint process is clearly defined and there are clear lines of accountability identified. There are four restraints being used in the facility. The service has three residents using enablers. Use of enablers is voluntary and the least restrictive options in order to meet the needs of the resident. The restraint assessments, consent, evaluations, monitoring and review are documented. The restraint risks are identified and reflected in the resident's person centred care plan.

Infection Prevention and Control

The service carries out surveillance of infections. The infection control coordinator reports to the quality meeting at monthly intervals. Infection control staff training occurred on 22 February and 3 March 2014. The service encourages hand washing throughout the facility. All hand basins are equipped with liquid soap and anti-bacterial gel. The service display posters and step-by-step guides on hand washing procedures to create and encourage infection control awareness.

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 and to the Oceania support office.

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 - Addington Lifestyle Care
Designated Auditing Agency:	Health Audit (NZ) Limited
Types of audit:	Certification Audit
Premises audited:	Addington Lifestyle Care
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: 6 August 2014 End date: 7 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:	97

Audit Team

Lead Auditor	XXXXXX	Hours on site	16	Hours off site	8
Other Auditors	XXXXXX	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	XXXXXX			Hours	3

Sample Totals

Total audit hours on site	32	Total audit hours off site	15	Total audit hours	47
Number of residents interviewed	6	Number of staff interviewed	11	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)	80	Number of relatives interviewed	7
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 Monday, 18 August 2014

Executive Summary of Audit

General Overview

Addington Lifestyle Care provided residential care for up to 97 residents who required hospital, rest home and dementia level of care. The occupancy on the days of the audit was at 97 (29 rest home, 28 dementia and 40 hospital residents). The facility is operated by the Oceania Care Company Limited. The residents and family interviewed provided positive feedback on the care services at the facility.

There were areas identified requiring improvement during this audit relating to the complaints processes, corrective action plans, informed consent, short term care plans and the medication management system.

Outcome 1.1: Consumer Rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the facility's complaints process and the Nationwide Health and Disability Advocacy Service information is accessible at the facility and provided to residents and their families on admission to the facility. The residents' individual privacy and dignity needs are assessed on admission. The residents' privacy is maintained and personal belongings are treated with respect. The residents and the family members interviewed confirm that their rights are met.

There is a documented Maori health plan which acknowledges the principles of the Treaty of Waitangi and is aimed at reducing barriers to access.

Written and verbal consent is gained where and when required. The residents are supported to maintain links with their family and the community.

The business and care manager is responsible for the management of complaints and a complaints register is maintained.

There are areas identified as requiring improvement around the informed consent and the complaint processes.

Outcome 1.2: Organisational Management

The Oceania Care Company Limited is the governing body and is responsible for the services provided at Addington Lifestyle Care. The services are appropriate and planned to meet the needs of the residents assessed as requiring rest home, hospital and dementia levels of care.

The organisation has a documented quality and risk management system in place. The required policies, procedures and work instructions are in place and accessible. There are systems in place for monitoring the services provided at Addington Lifestyle Care including regular monthly reporting by the business and care manager and the clinical manager to the Oceania support office. An internal audit programme is documented, however improvements are required to the consistency with which corrective action plans address all identified shortfalls are developed, implemented, monitored and signed off as being completed.

The risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risks.

The facility is managed by a suitably qualified and experienced business and care manager, who is a registered nurse. The business and care manager is supported by a clinical manager who is a registered nurse and who is responsible for oversight of clinical care provided.

Adverse events are documented on an accident/incident forms, as well as on an electronic database that is able to be reviewed by personnel in Oceania head office. The essential notifications are made where required. The adverse events are managed in an open and transparent manner. The collated adverse event data is communicated to staff.

The human resource management system is conducted in line with good employment practice. Prospective staff are screened and qualifications validated. All staff have a documented role description which outlines their key accountabilities and functions. The orientation and induction process ensures staff are aware of the essential components of service delivery at the facility. The validation of current annual practicing certificates for staff who require them to practise is occurring.

An in-service education is provided for staff and staff are supported to complete the New Zealand Qualifications Authority Unit Standards via the Oceania certificate in residential care. The planned education / training programme is implemented. Staff performance is monitored through the completion of defined competencies and annual performance appraisals. A review of staff records provide evidence that human resource processes are followed, orientation for new staff are completed and individual staff education records are maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The staff interviewed report there is adequate staff available and that they are able to get through their work. Staffing is appropriate to meet the needs of residents, with experienced advice and assistance available.

The resident information is entered into a register in an accurate and timely manner. The resident information is maintained in a hard copy integrated file. The information is appropriate in detail to the type of facility, is uniquely identifiable and kept current. Residents' personal information is secure and not publically accessible/observable. Records of past residents are maintained and archived off site.

Outcome 1.3: Continuum of Service Delivery

The admission agreement defines scope of service. The clinical manager confirms access and entry processes are followed. The service has an admission pack available for resident and their family who are new to the facility. Residents will only be declined entry if not within the scope of the service or if there is no bed available at the time of the enquiry. Residents who are declined to the service are informed of the reasons for decline of entry.

The service ensures continuity of service delivery through handover at the end of each shift, progress notes and entries to diaries and other records. Residents and family members are involved in the different stages of service provision. Residents' care plans are developed by the registered nurses and signed by family or the resident. Residents' risk assessments are completed on admission and the care plans include goals, interventions, assessments and six monthly reviews. Documentation and observations made of the provision of services and/or interventions, demonstrate that consultation and liaison is occurring with other services. Care plan evaluations are documented resident focused. There is a requirement for improvement relating to the service having to implement changes to the care plans when the resident's care needs change. The resident files sampled evidence referral forms and letters to nursing, allied health and medical specialists.

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

Medication rounds were observed in the dementia unit and in the hospital. The general practitioner signs and dates all entries to the medicines charts, allergies are recorded, each chart has resident's photo identification, and discontinued medicines are signed, crossed out and dated. There are two residents who self-administer medicines. All staff members who administer medicines complete annual competency testing.

The controlled drugs are stored securely. The controlled drug entries into the drug registers are checked weekly by registered nurses and the pharmacy does a six monthly drug stock-take of controlled drugs. The service monitors the medicines fridge temperatures daily. The service has a process for returning expired medicines to the pharmacy. There is a requirement for improvement relating to the general practitioner not consistently reviewing the medicines charts at three monthly intervals.

The food, fluid and nutritional needs of residents are provided in line with recognised guidelines that are appropriate to the residents' needs. The menus are reviewed annually by the dietitian from the Oceania support office.

Outcome 1.4: Safe and Appropriate Environment

There have not been any alterations undertaken to the building since the last audit although extensive refurbishment has occurred. There is a current building warrant of fitness. The facility is a single level building and accommodates all kitchen and laundry services.

All residents' bedrooms have full ensuites, except two rooms that share an ensuite. The residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids, as well as staff. The residents are provided with adequate and accessible areas for relaxation, activities and dining. There are lounges and sitting areas throughout the facility, as well as dining areas in each area of the facility.

There are safe and accessible external areas and well maintained paths and gardens. The external areas and gardens are available for sitting and shade is provided. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. The staff receive training in safe and appropriate handling of waste and hazardous substances. There are sluice facilities, safe storage of chemicals and equipment, and protective equipment and clothing provided and used by staff.

Review of documentation and visual observation provide evidence there are appropriate systems in place to ensure the residents' physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site. The cleaning and laundry systems include appropriate monitoring to evaluate the effectiveness of these services.

There are documented processes for the management of all emergency and security situations. All staff receive training in emergency management and first aid. There is an approved fire evacuation plan and fire drills are conducted six monthly. The service has planned for civil defence emergencies and has alternative energy and utility sources available if required.

The service endeavours to maintain the facility at the constantly comfortable temperature. There is adequate heating and ventilation.

Outcome 2: Restraint Minimisation and Safe Practice

The service actively works towards minimising restraint. The responsibility for the restraint process is clearly defined and there are clear lines of accountability identified. There are four restraints being used in the facility. The service has three residents using enablers. Use of enablers is voluntary and the least restrictive options in order to meet the needs of the resident. The restraint assessments, consent, evaluations, monitoring and review are documented. The restraint risks are identified and reflected in the resident's person centred care plan.

Outcome 3: Infection Prevention and Control

The service carries out surveillance of infections. The infection control coordinator reports to the quality meeting at monthly intervals. Infection control staff training occurred on 22 February and 3 March 2014.

The service encourages hand washing throughout the facility. All hand basins are equipped with liquid soap and anti-bacterial gel. The service display posters and step-by-step guides on hand washing procedures to create and encourage infection control awareness.

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 and to the Oceania support office.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	45	0	2	3	0	0
Criteria	0	96	0	2	3	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	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 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Moderate			
HDS(C)S.2008	Criterion 1.1.10.4	The service is able to demonstrate that written consent is obtained where required.	PA Moderate	Three out of ten advanced directive stating the resident is 'not for resuscitation' are signed by the enduring power of attorney.	Advanced directive stating 'not for resuscitation' can only be signed by a resident who is able to make such a decision.	30
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.1.13.1	The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	Not all complaints evidence an acknowledgement is provided in writing within five days of receipt of the complaint.	Provide evidence the compliant processes are implemented to comply with the Right 10 of the Code and the policy.	180
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	(i) Review of internal audits and sentinel events evidence that corrective action plans are not being consistently documented, implemented and monitored to address all areas identified as requiring improvement. (ii) The name / designation of the person/s responsible for implementation of the corrective action/s and the timeframe/s are not being consistently documented.	i) Provide evidence corrective action plans are being developed, implemented, monitored and signed off as having been completed. (ii) Provide evidence the name / designation of the person/s responsible for the corrective action plan/s is documented along with timeframes for the corrective actions.	180
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service	PA Moderate	Two of the three residents files reviewed do not have short term care plans reflecting their changed needs.	Where a resident's care needs changes the service are to respond by initiating changes to the service delivery plan.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		delivery plan.				
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	The GP does not consistently review the medicines charts at three monthly intervals.	All medicine charts to be reviewed at three monthly intervals.	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

Standard 1.1.1: 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:

Six of six residents (two hospital, one dementia and three rest home) and seven of seven family members (two hospital, one rest home and four dementia) are able to verify that residents' privacy is maintained, and residents' individual needs and rights are upheld.

The interviews with staff (the business and care manager, the clinical manager, three registered nurses, three health care assistants, the activities co-ordinator) demonstrate an understanding of the resident rights. The education records reviewed indicate that staff attend training in resident rights as part of their orientation, as well as part of the ongoing education programme. This education was last provided in February 2014. The staff files (nine of nine) sampled evidence that staff attend education on the Code and also complete the Code of Rights questionnaires. The staff are observed interacting respectfully and communicating appropriately with residents.

An audit on the Code of Rights was last conducted in June 2014 with corrective action addressed.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

The Code of Rights and information on the advocacy service are displayed and are available at the facility and in the information pack provided to residents and their family on admission to the facility.

The residents and family members interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service. The enquiry / admission pack is reviewed and contains all relevant information.

The residents' meetings are held monthly and review of the meeting minutes records residents and family involvement.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The residents are observed being treated with respect by staff during this audit. The residents' personal belongings are appropriately stored and the residents have access to their own clothing and personal items. The visual observations evidence residents' bedroom doors are closed for privacy, the staff are observed knocking before entering residents' rooms and no private or sensitive interventions are observed during the audit. The resident and family interviews confirm privacy is maintained. The residents' individual privacy and dignity needs are assessed on admission.

All residents' rooms have full en-suites except two hospital rooms where an en-suite is shared. Both residents who share the en-suite facility require staff to assist them with personal care. An interview with one resident sharing an en-suite confirms there are no privacy issues.

The staff receive training on abuse / neglect and the last education was provided in December 2013. There are documented procedures and guidelines for staff regarding the identification and management of abuse and neglect. Staff boundaries are monitored and the adverse event reporting system ensures any identified breach in boundaries is investigated.

The residents are supported in activities in the community and where a resident wishes to continue with their hobbies or self-cares this is encouraged. Church services are held on site as part of the activities programme.

Values, beliefs and cultural aspects of care are recorded in residents' clinical files reviewed (four hospital, three rest home and three dementia).

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

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

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

Attainment and Risk: FA

Evidence:

There are currently no residents in the facility that identify as Māori. A cultural assessment is completed as part of the person centred care plan for all residents and is sighted on the 10 of 10 residents' files reviewed.

The business and care manager states access to Māori support and advocacy services is available if required. The family are able to be involved in the care of their family members.

The care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. The cultural safety education was last provided in April and May 2014.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The documentation reviewed during this audit provides evidence that appropriate culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs.

The residents' files reviewed demonstrate that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whanau contact details. All residents have a cultural assessment completed as part of the care planning process. The business and care manager advises there is one resident at the facility for whom English is a second language and that their ethnic, cultural and spiritual beliefs are recorded and respected by staff.

The residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. The church services are held on site as part of the activities programme.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Evidence:

There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation. Oceania policies and procedures include complaints and a code of conduct that includes house rules. These documents also address any conflict of interest issues (e.g. the accepting of gifts).

The expected staff practice is outlined in job descriptions and employment contracts, which are reviewed on nine of nine staff files.

The residents and family interviewed report that staff maintain appropriate professional boundaries. The care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

Systems are in place to ensure staff receive a range of opportunities which promote good practice within the facility. The documentation reviewed provides evidence that policies and procedures are based on evidence-based rationales.

The staff education is provided as part of the in-service education programme and this is confirmed during review of education records and interview of the business and care manager, the clinical manager, the registered nurses and the health care assistants, who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. Staff interviewed confirm understanding of professional boundaries and practice.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. The 10 of 10 residents' files reviewed (three rest home, four hospital and three dementia) provide evidence that communication with family members is being documented in the residents' records. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, on family communication sheets, and in the individual resident's files. The staff education on open disclosure was last conducted in September 2103.

Visual observation evidences that since the last surveillance audit a family/ whanau room has been created for relatives to use.

The residents and family interviewed confirm that staff communicate well with them. The residents interviewed confirm that they are aware of the staff that are responsible for their care.

The business and care manager advises access to interpreter services is available if required. There is one resident at the facility for whom English is a second language. The business and care manager states the resident's family provide interpretation for the resident and there are two staff members who are able to communicate with the resident.

The residents and their family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Ten of 10 admission agreements are reviewed and this is communicated in each agreement.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Residents and family of choice are provided with information in order to make informed decisions and therefore give informed consent. Ten of 10 resident files reviewed evidence general consent, however consents for advance directive stating 'not for resuscitation' are currently signed by the enduring power of attorneys.

Residents and family participate in their recovery, care, treatment and support as well as decision making processes, confirmed at six resident (three rest home, two hospital and one dementia) and seven family (one rest home, two hospital and four dementia) interviews.

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

The district health board contract requirements are not fully met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

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

Attainment and Risk: PA Moderate

Evidence:

The service demonstrates that written consent is obtained where required, sighted 10 of 10 general consents obtained from residents however the consents obtained where 'not for resuscitation is indicated' (NFR), three of the ten are signed by the enduring power of attorney (EPOA). The service immediately started implementing corrective actions.

Finding:

Three out of ten advanced directive stating the resident is 'not for resuscitation' are signed by the enduring power of attorney.

Corrective Action:

Advanced directive stating 'not for resuscitation' can only be signed by a resident who is able to make such a decision.

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

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.11: 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:

There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. The staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. The staff interviewed confirm they have been provided with education on the Code of Rights, advocacy, and complaint management as part of the in-service education programme. This was confirmed during review of staff education records and staff files.

The residents and family interviewed confirm that advocacy support is available to them if required, and that information on how to access the Health and Disability Advocate is included in the information package they receive on admission. Visual inspection provides evidence the nationwide advocate details are displayed along with advocacy information brochures. An admission / enquiry pack is reviewed and provides evidence advocacy, complaints and Code of Rights information is included.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service (e.g. visitors are required to sign in and out via registers). The activities programme includes access to community groups.

The residents interviewed confirm they have access to visitors of their choice, and confirm they are supported to access services within the community. The access to community support/interest groups is facilitated for residents as appropriate and a mobility van is available to take residents on community visits.

The residents' files reviewed demonstrate that activity plans identify support/interest groups. The residents' progress notes include records of outings and appointments.

There is evidence of family involvement at residents' meetings, minutes sighted. Evidence was sighted of communication with residents and family in respect of their input in the development of new admission information brochure.

The district health board contract requirements are met.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The business and care manager is responsible for complaints and there are appropriate systems in place to manage the complaint processes. A complaint register is maintained and the 2013 and 2014 complaint registers are reviewed.

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

The complaint policies and procedures are compliant with Right 10 of the Code. The systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Six of six residents (two hospital, three rest home and one dementia) and seven of seven family (two hospital, one rest home and four dementia) interviewed demonstrate an understanding and awareness of these processes. The resident meetings are held monthly and residents are given opportunity to be able to raise any issues.

A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. The review of quality and staff meeting minutes and the business and care manager's monthly reports to Oceania head office provide evidence of reporting of complaints to the governing body and staff. The staff interviewed confirm this information is reported to them via the staff meetings.

The staff education on complaint management was conducted in April and June 2014. An audit on complaint management was conducted in May 2014 with corrective action to be addressed (refer to 1.2.3.8).

There is an area requiring improvement around the complaints management processes.

The district health board contract requirements are not fully met.

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

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

Attainment and Risk: PA Low

Evidence:

The complaint policies and procedures are compliant with Right 10 of the Code. The systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Two of seven complaints reviewed evidence the acknowledgement is not provided in writing within five days of receipt of the complaint.

Finding:

Not all complaints evidence an acknowledgement is provided in writing within five days of receipt of the complaint.

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

The Oceania Care Company Limited (Oceania) is the governing body and is responsible for the services provided at Addington Lifestyle Care. The Oceania scope, direction, goals and vision are displayed at entrance to the facility. A written quality and risk management plan/policy identifying the organization's quality goals, objectives, and scope of service delivery is reviewed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.

The systems are in place for monitoring the service provided at Addington Lifestyle Care including regular monthly reporting by the business and care manager (BCM) and the clinical manager (CM) to Oceania head office via the Oceania intranet. The reporting includes reporting on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators and this is sighted during the audit. The monthly business status reports are provided to the Oceania executive team and link to the organisations and facility's business plan.

The BCM is an experienced registered nurse who has been in this position since April 2013. The BCM is supported in their role by a clinical manager (CM), who is also a registered nurse. There has been a change of clinical manager since the last surveillance audit. These two managers are supported by the Oceania clinical and quality manager, as well as a regional business operations manager from Oceania. The Oceania clinical and quality manager is interviewed and describes the support processes for the facility and staff. The managers' CVs and personal files are reviewed and there is documented evidence they attend education to keep themselves up-to-date.

Addington Lifestyle Care is certified to provide hospital (medical and geriatric), rest home level care and dementia level of care to residents. On day one of this audit there are 29 residents assessed as requiring rest home level care, 40 residents assessed as requiring hospital level care aged and 28 residents requiring dementia level of care. Dementia unit accommodates more than 20 residents and conversation with the Oceania senior clinical and quality manager confirms this exemption is approved by the DHB (as per ARRC contract E3.3a).

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.2: 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:

Evidence:

There are appropriate systems in place to ensure the day-to-day operations of the service continues should the business and care manager (BCM) and/or the clinical manager (CM) be absent. The CM relieves the BCM if they are absent and the BCM relieves the CM if they are absent. There is support from the clinical and quality manager from Oceania. Twenty four hour registered nurse (RN) cover is provided. Both the BCM and CM are on call after hours, if required. The BCM states for longer periods of temporary absence (more than one week) Oceania head office would arrange for another BCM from another facility to provide cover.

Additional support and assistance is provided by other personnel from Oceania head office as required. Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the BCM and CM confirms their responsibility and authority for their roles.

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: PA Low

Evidence:

The Oceania quality improvement policies and procedures record quality goals and objectives and guide the implementation of the quality programme at the facility. The clinical indicators and risk issues are documented on an electronic database that is able to be reviewed by personnel from Oceania head office and they are also reported on in the facility's meetings. This is confirmed at review of the database and the meeting minutes. The internal audit schedule and the completed audits for 2013 and 2014 are reviewed during this audit. The review of the quality improvement data provides evidence the data is being collected and collated, however the corrective actions are not consistently recorded, implemented and evaluated and this requires an improvement. The resident / relative satisfaction survey was conducted in July 2014. The results of the satisfaction survey evidence corrective action are required and there is a documented corrective action plan identifying the areas requiring improvement.

The Oceania policies and procedures reflect current accepted good practice and identify relevant standards and legislative requirements. There are systems in place for reviewing and updating the policies and procedures regularly. The staff report copies of policies are available for staff and they are advised of updated policies via the staff and quality meetings, confirmed at the review of meeting minutes and visual observation of the nurses' stations. The meeting minutes are reviewed and provide evidence of discussion and reporting on quality issues.

The health and safety manual documents health and safety management systems including a health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements, and an emergency plan. The health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risks are documented. Oceania holds Workplace Safety Management Practices accreditation at tertiary level for ACC workplace safety and this expires on 31st March 2015. The health and safety audit was last conducted in June 2014 with 100% compliance.

The district health board contract requirements are not fully met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

The quality and risk management data and quality improvement data is reported on at the facility's meetings and to the Oceania head office.

Finding:

(i) Review of internal audits and sentinel events evidence that corrective action plans are not being consistently documented, implemented and monitored to address all areas identified as requiring improvement.

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

Corrective Action:

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an adverse event reporting system in place that ensures all accident/incidents are recorded and reported. The business and care manager (BCM) and/or the clinical manager (CM) enter the accidents and incidents on the Oceania intranet as part of the reporting of monthly clinical indicators. The accidents / incidents recorded include but are not limited to events relating to: absconding; choking; falls; infections; medication errors; sentinel events; wounds and abuse.

The resident files reviewed provide evidence that accident/incident forms are fully completed. The review of accident/incident forms evidence residents' neurological observations are recorded where required following a fall and the post assessment forms are also completed for residents who have falls.

The communication with families following adverse events, or any change in residents' condition is evidenced in the residents' files reviewed. The staff education on adverse events was last held in March 2014. During interviews the staff demonstrate an awareness of the adverse event process.

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

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.

<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 1.2.4.3 (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.

<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 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

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

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

Attainment and Risk: FA

Evidence:

The clinical manager (CM) advises they are responsible for overseeing and providing education for staff at the facility. The CM advises an annual education plan is developed that is based on the Oceania education plan. The staff at the facility are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Oceania certificate in residential care programme. Interview with the administrator confirms monitoring of the staff attendance at education sessions and an in-service attendance register is sighted. The in-service education plans, staff competency registers and staff education records are maintained and are reviewed for 2013 and 2014.

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

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

The health care assistants and the RNs working all shifts in all three areas of the facility confirm they have completed an orientation, including competency assessments (as appropriate). The staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

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 documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The BCM and/or the CM are on call after hours.

Care staff interviewed report there is adequate staff available and that they are able to get through the work allocated to them. The residents and family members interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit confirm adequate staff cover is provided. The minimal staff cover occurs on night shifts, with one registered nurse (RN) and sufficient number of health care assistants to meet the health and personal care needs of residents. The distribution of care staff over a 24 hour period is in accordance with the needs of the residents.

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:

Evidence:

The resident information is entered in an accurate and timely manner into registers (electronic and hard copy) that are appropriate to the service and in line with legislative requirements. An interview with the administrator confirms the resident details are entered into an electronic record and hard copy on their day of admission.

The resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed. The resident files reviewed provide evidence that an entry into the resident's clinical record is made on each shift and entries are clear, dated and signed.

A visual inspection of the facility provides evidence that residents' information is stored in staff areas and is held securely and is not on public display. The residents' clinical files are current and are accessible to all clinical staff. The resident's NHI number, name, and date of birth are used as the unique identifiers.

The administration staff and the clinical staff interviewed confirm they know how to maintain confidentiality of resident information. The historical records are held securely off site and are accessible, confirmed at the administrator interview.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and procedures for entry criteria, assessment and entry screening are recorded and implemented. The service's philosophy is recorded, displayed at the facility and communicated to residents, family, relevant agencies and staff. The service provides information to referral sources and operates 24/7. The admission agreement defines scope of service and includes the contractual requirements; ten sampled files evidence signed and dated admission agreements. The clinical manager interview confirms access and entry processes are followed. The service has an admission pack available for residents and their family who are new to the facility

Residents' files sampled demonstrate needs assessments are completed for appropriate level of care (three rest home, four hospital and three dementia resident files) and confirmed during interview with the general practitioner. Interviews with six residents (three rest home, two hospital and one dementia) and seven family members (one rest home, two hospital and four dementia) confirm the admission process is conducted by staff in timely manner and relevant admission information is provided. Staff members discuss care and treatment with residents, confirmed during three health care assistants and three RN interviews.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The scope of the service provided at the facility is identified and communicated to prospective residents and their families confirmed during the interview with the clinical manager. The service has a system in place for informing people who are declined to the service, confirmed during the clinical and quality manager and the clinical manager's interviews. The clinical manager states residents will only be declined entry if not within the scope of the service or if there is no bed available at the time of the enquiry. People who are declined to the service are informed of the reasons for decline of entry and referred back to the needs assessment service coordination services (NASC), confirmed at the facility administrator interview.

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:

Ten resident's files are sampled. The files evidence the stages of service provision developed by the staff. Services promote continuity of service delivery; the auditor attends handover in the dementia unit and in the hospital. Staff interviews (three health care assistants and three registered nurses) confirm residents and/or family members are involved in the different stages of service provision. Care plans are developed by the RN's (confirmed during interviews) and signed by family or the resident (sighted) and residents confirm they have input to their person centred care plans. Sampled files evidence nursing assessments meet appropriate timeframes. Family communication sheets are maintained, sighted in 10 residents' files. There are two requirements for improvement relating to the tracers and the 10 sampled files (Refer to 1.3.8.3).

Where records identify an enduring power of attorney (EPOA), the service has legal documentation to support such a role. Resuscitation and consents are signed (Refer to 1.1.10.4).

Tracer methodology in the hospital

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

Tracer methodology in the rest home

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

Tracer methodology in the dementia unit

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

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.4: 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:

Residents' files reviewed (10 out of 10) evidence risk assessments including continence, balance, gait, pain, falls, oral, mobility, nutrition, cultural and pressure area assessments. Assessments are conducted in a timely manner and risk assessment findings are reflected in the person centred care plans (PCCP), sighted.

Initial care plans are completed on admission, signed by the RN and by the resident or family, confirmed at staff (three RN's and the clinical manager) resident and family interviews. Needs, outcomes and goals are consistently with the PCCP's, verified. Outcomes and goals are specific to the needs of the residents, verified in 10 of 10 resident records.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Ten out of 10 resident files sampled evidence residents' person centred care plans are individualised, personalised and up-to-date. The long-term and short-term goals are identified by the residents and service providers and reviewed at regular intervals, at least six monthly or as needs change, sighted. Residents have input into their care planning and review, confirmed at six resident (three rest home, two hospital and one dementia) and seven family (one rest home, two hospital and four dementia unit) interviews.

Staff members interviewed (the clinical manager and three RN's) confirm that care plans are accurate and up to date, sighted. Ten resident files sampled evidence the clinical care, treatment, support or interventions that is provided by the staff, is current. Risk assessments are recorded on the care plans and there is evidence of care plan discussion and sign-off by residents and family members.

The facility has access to several general practitioners (GP) however one GP is responsible for the care of the majority of the residents, confirmed during interview with the GP. Interview with the GP confirms being satisfied with the levels of care rendered.

The district health board contract requirements are met.

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

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the on going 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:

Documentation and observations made of the provision of services and/or interventions, demonstrate that consultation and liaison is occurring with other services, sighted referral documents in resident files. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the service agreement, sighted by the lead auditor during the on-site audit. Interview with the GP, the clinical manager and 10 residents' files sampled evidence care plans record interventions based on assessed needs, desired outcomes / goals of the residents. The person centred care plans (PCCP's) include cultural needs, sexuality, spiritual needs and residents or relatives are signing the care plans in demonstration of their participation in the care planning process.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility has an activity coordinator (AC) who has been with the facility for eight years and a diversional therapist (DT) who is newly appointed to the role and currently undergoing induction and orientation. The AC works 75 hours per fortnight Monday to Friday during the hours of 0900 to 1700, confirmed during interview with the activities coordinator.

The AC is currently still responsible for the development of the programmes for the three different areas of service delivery (rest home, hospital and dementia), sighted the monthly programmes for May to July 2014.

Six residents, seven family and staff interviews confirm the activities programme includes input from external agencies, supports ordinary and unplanned / spontaneous activities including festive occasions and celebrations. Residents' meeting minutes evidence residents' discussion in relation to the activities programme, sighted minutes from meetings in February to June 2014. Residents meeting are being held monthly on the first Tuesday of the month, confirmed during the AC interview.

Ten of 10 residents' files sampled demonstrate the individual activities service plans are current and demonstrate support is provided. Current residents' activities assessments were sighted in all 10 residents' files sampled.

Interview with the activities coordinator, six residents and seven family members confirm the activities programme meets the needs of the service group and the service has appropriate equipment. Dementia residents participate in group and one-on-one activities where appropriate, sighted during the on-site audit days.

Residents interviewed confirm their past activities are considered and their enjoyment of the activities they choose to participate in. Activities attendance records are maintained and are sighted.

The district health board contract requirements are met.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Evaluations are documented, resident focussed and indicate the degree of response to interventions and the progress towards meeting the resident's goals however, two of the three residents whose care does not have short term care plans reflecting their changed needs. Four out of 10 resident files reviewed show that their assessments do not reflect their immediate care needs.

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

Evidence:

Residents whose progress is different from the expected are reviewed. Two of the three residents whose care do not have short term care plans or wound care plans, reflecting their changed needs (Refer to 1.3.3.3).

Finding:

Two of the three residents followed do not have short term care plans reflecting their changed needs.

Corrective Action:

Where a resident's care needs changes the service are to respond by initiating changes to the service delivery plan.

Timeframe (days): 30 (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:

Ten out of 10 resident documentation and records show they have choices regarding access and referrals to other health or disability services. Resident files sampled (three in the rest home, four in the hospital and three in the dementia unit) evidence referral forms and letters to nursing and medical specialists, the NASC assessment team and specialist services at the Canterbury district health board (CDHB).

The service maintains effective family communication, confirmed during six resident and seven family interviews and supported by resident records such as progress notes. The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

Service providers identify, document and minimise risks associated with each resident's transition, exit, discharge and or transfer, including expressed concerns of the resident and the family, confirmed during interview with the clinical manager and the registered nurse. The service uses a specific transfer form to document areas of potential risk for the residents which include personal detail of the resident, risk assessment information, the person centred care plan (PCCP) and a copy of the medicines chart and medicines administration record.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Visual inspection of the medication areas in the rest home, hospital and dementia unit, evidence appropriate and secure medicine administration system, free from heat, moisture and light, with medicines stored in original dispensed packs. There are two controlled drugs storage in the facility in the hospital and in the dementia unit, which is secure. The controlled drug registers are maintained and evidence weekly checks by the registered nurses and six monthly physical stock takes of controlled drugs by the Pharmacist are noted on the registers.

Twenty medicines files are reviewed (six in the rest home, eight in the hospital and six in the dementia unit). Residents' medicines charts list all medications a resident is taking (including name, dose, frequency and route to be given). There is evidence staff are signing off, as the dose is administered. Medication rounds are observed in dementia unit and in the hospital.

Twenty six staff authorised to administer medicines have current competencies, 16 health care assistants (HCA), two EN's and eight RN's. Staff education in medicine management was conducted in May 2014. Twenty medicine charts (six rest home, eight hospital and six dementia) were sampled, the GP signs and dates all entries, allergies are recorded, each chart has photo identification, 17 of the files sampled show that the GP crosses out discontinued medicines, signs and dates discontinued medicines, however the GP does not consistently review the medicines charts at three monthly intervals.

There are two residents that self-administer medicines, sighted and reviewed their assessments for competency, administration records and that they have safe and appropriate storage areas for keeping the medicines.

There is one requirement for improvement regarding three monthly reviews of residents to be consistently completed and recorded.

The district health board contract requirements are not fully met.

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

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

Attainment and Risk: PA Moderate

Evidence:

Twenty medicine charts (six rest home, eight hospital and six dementia) were reviewed. The GP signs and dates all entries, records allergies, medicines charts have photo identification, 17 of the files sampled show that the GP crosses out, signs and dates discontinued medicines, however the GP does not consistently review the medicines charts at three monthly intervals.

Finding:

The GP does not consistently review the medicines charts at three monthly intervals.

Corrective Action:

All medicine charts to be reviewed at three monthly intervals.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Food policies and procedures and services are appropriate to the service setting, providing summer and winter menus that rotate every four weeks. The menu is developed by a dietitian, last reviewed in March 2014, confirmed by the cook during interview and sighted. Food procurement, production, preparation, storage and disposal comply with requirements, sighted food stores and confirmed during visual inspection of the kitchen. The chef keeps daily records of fridge, freezer and chiller temperatures, sighted. Food temperatures are monitored, every hot dish at every meal is monitored for its temperature, sighted records.

Resident's individual dietary needs are identified, documented and reviewed as part of the person centred care plan (PCCP) review. The cook is informed when resident's dietary needs change, confirmed during interview and sighted copies of the dietary assessments. Additional food and snacks are available for residents, confirmed during resident and family interviews. Residents are offered fluids throughout the day, verified. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Residents' files sampled demonstrate regular monthly monitoring of individual resident's weight. Residents and relatives surveys confirm they are mostly satisfied with food services. Three out of fourteen feedback records show the service could be better however they still rated the food as good.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There are documented processes for the management of waste and hazardous substances in place. Material safety data sheets are available throughout the facility and are accessible for staff. A hazard register is sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and the education was last provided in January 2014 by chemical supplier. This finding is confirmed during interviews of domestic staff and review of staff education records.

Monthly visits are made by the chemical supplier representative who reviews kitchen, cleaning and laundry processes, observed on first day of audit.

The sluice facilities are available for the disposal of waste and hazardous substances. A visual inspection of the facility provides evidence that protective clothing and equipment is appropriate to the risks associated with the waste or hazardous substance being handled and is being used by staff. The hazardous substances sighted are correctly labelled.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There have not been any alterations undertaken to the building since the last audit although extensive refurbishment has occurred. The business and care manager confirms an ongoing refurbishment programme is in place. Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose.

The maintenance person is employed full time and is interviewed during this audit. The maintenance person confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. The documentation reviewed and visual inspection confirms this. The planned and reactive maintenance systems are in place and are reviewed during this audit along with current calibration / performance reports for medical equipment. A current building warrant of fitness is displayed that expires on 1 May 2015.

A visual inspection of the facility provides evidence the medical equipment is safely stored. The corridors are wide enough to allow the residents to pass each other safely. The safety rails are secure and are appropriately located. The equipment does not clutter passageways, a new hoist bay has been built to store hoists in one area and to prevent clutter in hallways. The floor surfaces/coverings are appropriate to the resident group and setting and are maintained in good order. The residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

There are several external areas available that are safely maintained and are appropriate to the resident group and setting. The residents are protected from risks associated with being outside (e.g., safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; and ensuring a safe area is available for recreation or evacuation purposes). The dementia unit has a secure external area.

The staff receive education in the safe use of medical equipment and there is a system in place to review staff competency for specific equipment (e.g. hoists competency). This is confirmed during interview of staff and review of the staff education records. The clinical staff interviewed confirm that they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.

The facility inspection audit was conducted in July 2014 with 100% compliance.

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.)*

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:

All residents' rooms have full en-suites except two hospital rooms where an en-suite is shared. Both residents who share the en-suite facility require staff to assist them with personal care. An interview with one resident sharing an en-suite confirms there are no privacy issues. The communal toilet facility is located close to the dining and lounge areas. The business and care manager states the communal toilet is not often used by residents, as residents use their personal en-suites. There are separate visitors and staff toilets.

A visual inspection provides evidence that toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. The hot water temperatures are monitored at monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions). The maintenance person states if the hot water temperatures exceed the recommended temperature range, that corrective action is taken to address the issue, however this is not always recorded (refer to 1.2.3.8).

The residents' bathrooms/ en-suites have appropriate access, meet specifications for people with disabilities, and are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two staff. The communal toilet facilities have a system that indicates if it is engaged or vacant. An appropriately secured and approved handrails are provided in the en-suites and other equipment/accessories are made available to promote resident independence.

The district health board contract requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Visual inspection provides evidence that the bedrooms allow for easy access for mobility aids. The bedrooms are large enough to allow residents and staff to move around within the room safely and adequate personal space is provided. This finding was confirmed during interviews of staff and residents. The resident's bedrooms are personalised to varying degrees. The district health board contract requirements are met.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

A visual inspection provides evidence that adequate access is provided to lounges and dining rooms throughout the facility. The residents are observed moving freely within these areas. The residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The cleaning and laundry policy and procedures are available for staff. There are policies and procedures for the safe storage and use of chemicals / poisons .

There is dirty / clean flow in the laundry and the laundry personnel interviewed describe the management of laundry including transportation, sorting, storage, laundering, and return to residents.

A visual inspection provides evidence that cleaning and laundry processes are implemented. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and monthly visits from the chemical company representative. Both the cleaning audit (May 2014) and the laundry audit (July 2013) results record 100% compliance. The cleaning and laundry staff are observed using personal protective equipment. The residents interviewed state they are satisfied with the cleaning and laundry service.

A visual inspection of the facility provides evidence that safe and secure storage areas are available and staff have appropriate and adequate access to these areas. The chemicals are labelled and stored safely and the chemical safety data sheets are available. Appropriate facilities exist for the disposal of soiled water/waste. Hand washing facilities are available and hygiene standards are maintained in storage areas.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Attainment and Risk: FA

Evidence:

There are documented systems in place for essential, emergency and security services. There is a New Zealand Fire Service (NZFS) letter advising the fire evacuation scheme approval, sighted. The trial evacuations are held six monthly, sighted.

The staff interviews and review of nine of nine staff files provide evidence of current training in relevant areas. The staff confirm recent education on fire, emergency and security situations. The emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. The staff records sampled provide evidence of current training regarding fire, emergency and security education. The emergency management training was last provided in May 2014.

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

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

A call bell system used by the residents, visitors or staff members to summon assistance is accessible / within reach, and are available in resident areas. The residents interviewed confirm they have a call bell system in place which is accessible and staff generally responds to it in a timely manner.

The district health board contract requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. The documentation and visual inspection provide evidence that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The residents interviewed confirm the facilities are maintained at an appropriate temperature.

The district health board contract requirements are met.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The service has systems in place to ensure restraint use is minimized. The facility was utilising four restraints during the first onsite audit day and there was three enablers being used, sighted the restraint register. Restraints are in the form of bedrails and lap belts and enablers are in the form of bedrails and lap belts. Staff interviews and records evidence restraint minimisation and safe practice (RMSP) as well as challenging behaviour training took place in July 2014.

The process of assessment and evaluation of restraint use is recorded and includes assessments for restraint use, consent processes which include the resident and or family, restraint being included in the person centred care plan (PCCP), restraint risks being identified and reflected in the PCCP, monitoring records and review of restraints.

Review of all the restraints occurred, verified. Four resident files are reviewed for restraint.
The district health board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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:

There are processes for determining restraint approval, sighted all the restraint consent records. Staff members interviewed and residents' files sampled evidence responsibilities are clearly identified and recorded. Residents' files sampled evidence input into the restraint approval processes from resident's and family members.

The service has a monthly restraint committee meeting, sighted meeting minutes from January to July 2014. The restraint committee evidence an approval review process. The role of the restraint coordinator (RC) is the responsibility of one of the registered nurses in the hospital who is suitably experienced and qualified.

Clinical staff members are aware of the restraint co-ordinator's responsibilities, interviewed three health care assistants (HCA's). Orientation and induction programmes for new staff members include an overview of the restraint minimisation and safe practice (RMSP) policies and procedures. The district health board contract 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:

Systems are in place to ensure assessment of residents is undertaken prior to restraint usage being implemented, sighted restraint assessments for four residents. Residents' files sampled demonstrate restraint assessment and risk processes are being followed. Residents' files sampled, where restraint is utilised, evidence restraint assessment risks are documented and evaluated three monthly or when the resident's needs change and include resident and / or family input.

Multidisciplinary reviews evidence restraint assessment risks are reviewed and the GP signs each restraint form, sighted.
The district health board contract requirements are met

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The service has systems in place to ensure restraint is used safely. Restraint policies and procedures identify risk processes to be followed when a resident is being restrained. The monthly reports to the support office include data on restraint use. Residents' files sampled evidence evaluations / review of restraint goals and interventions.

Four residents' files reviewed for restraint demonstrate appropriate alternative interventions are implemented and de-escalation is attempted prior to initiating restraint. Four of the four residents' files reviewed demonstrate details of the reasons for initiating the restraint, alternative interventions attempted or considered prior to the use of restraint and advocacy/support services offered. The restraint register records information to provide an auditable record of restraint use. During the onsite days of audit there were four residents utilising restraint and three residents requesting the use of enablers.

Staff education in challenging behaviour and restraint minimisation occurred on 2 February 2014, 3 March 2014 and 22 April 2014.
The district health board contract requirements are met

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The facility's restraint evaluation processes are documented in the restraint minimisation and safe practice policy (RMSP). Four residents' files reviewed for restraint, evidence that each episode of restraint is being evaluated and based on the risk of the restraint being used.

Policies guide the service in relation to strategies to minimise use of restraint and management of challenging behaviour. The restraint committee meeting minutes for January to April 2014 are sighted. Evaluations of restraint include (a) to (k) in this criterion. Four residents' files reviewed for restraint practices demonstrate residents' person centred care plan (PCCP) evaluations and multidisciplinary meetings are current. The PCCP's reflect the restraint use. The district health board contract requirements are met.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Restraint monitoring and quality review occur three monthly, reviewed four resident files regarding restraint. Restraint reviews are documented and reported on to support office at Oceania Care Group as part of the quality indicators. Restraints are also discussed at the monthly staff meetings. The RMSP policies and procedures include monitoring and quality review processes. The restraint committee meeting minutes for January to April 2014, sighted. The district health board contract requirements are met.

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

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

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

- (g) Whether changes to policy, procedures, or guidelines are required; and
(h) Whether there are additional education or training needs or changes required to existing education.

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

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:
Interviews with three registered nurses (RN's) and three health care assistants (HCA's) confirm they are able to identify the infection control coordinator who is also the clinical manager of the facility.
Infection control meetings are held monthly and feedback is given to staff members at monthly staff meetings, sighted monthly staff meeting minutes for January to July 2014. The infection control coordinator (ICC) has a signed job description with responsibilities relating to the role, sighted. The responsibilities of the infection control coordinator includes monitoring and surveillance of infections on a monthly basis, collating the information and including the data in the monthly report to the support office of the Oceania Care Group.
Data is reported as part of the key quality indicators. The Infection control program is maintained and updated by the organisation. Alcohol hand gel is available throughout the facility and at the front reception for use. The district health board contract 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.

<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 3.1.3 (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>

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Infection control meetings are held monthly, confirmed during interview of the infection control coordinator. The infection control coordinator completed Infection Prevention and Control training (level 1 and level 2) offered by Oceania Care Group during 21 and 23 July 2014, sighted the training planner and confirmed at the clinical manager interview. The ICC is responsible for internal training of staff.

Signs relating to hand washing processes and hand washing instructions are displayed in the nurses station's and at hand-basins in the kitchen, the laundry room and the sluice room confirmed during the visual inspection of the facility. The ICC keeps an Infection control resource folder to assist in infection control training.

Staff members confirm they participate in infection prevention and control in the facility.
The district health board contract requirement is 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:

Policies and procedures for the prevention and control of infection comply with relevant legislation and current accepted good practice (Refer 3.2). The infection control policy and programme is reviewed for 2014 to 2016. The service has access to micro-biologists at the laboratory and the infection control nurse specialist at the Canterbury District Health Board, confirmed during interview of the ICC.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

A review of the education folders shows that training was provided by the infection control coordinator on 22 January 2014 and 3 March 2014 including infection control and hand hygiene. Interviews with residents and resident families show they are aware of the importance of hand washing and the use of alcohol gels. The service offers

education and training regarding hand washing procedures to residents in an informal manner during service delivery and to staff as part of education and training for staff members.

The district health board contract requirement is 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:

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

Interview with the infection control coordinator confirms surveillance is carried out in accordance with the service's infection control policies. The management of infections include residents having short term care plans to guide the service, however the short term care plan for the resident does not have a short term care plan completed (Refer to 1.3.8.3).

The surveillance data summarise infections and the analysis is expressed in reports to the support office, sighted records. Infection control data is analysed at clinical and quality management level and internally benchmarked.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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