

Oceania Care Company Limited - Woodlands Rest Home & Village

Current Status: 15 September 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Partial Provisional 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

Woodlands Lifecare is currently providing rest home and hospital level care in a 63 bed facility. The service provider has converted an existing 17 bed rest home wing in to a secure area that they are proposing to open in late October 2014. This audit is undertaken to establish the level of preparedness of the provider to provide this newly configured service. The facility is operated by Oceania Care Company Limited. Four areas were identified as requiring improvement during this audit relating to evidence the existing fire evacuation scheme remains approved by the New Zealand Fire Service, the safety of the external secure area, management of medicines including medication documentation and safe storage of medicines for a resident who self administers their own medicines.

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 - Woodlands Rest Home & Village

Designated Auditing Agency:	Health Audit (NZ) Limited
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Types of audit:	Partial Provisional Audit
Premises audited:	Woodlands Rest Home & Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 September 2014 End date: 15 September 2014

Proposed changes to current services (if any):

Currently providing hospital and rest home services in a 63 bed facility. Reconfiguration of services to convert 17 of the 47 rest home beds into a secure dementia unit for the provision of dementia services.

Total beds occupied across all premises included in the audit on the first day of the audit:	38
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Audit Team

Lead Auditor	XXXXX	Hours on site	6.5	Hours off site	5.5
Other Auditors	XXXX	Total hours on site	6.5	Total hours off site	5.5
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	13	Total audit hours off site	13	Total audit hours	26
Number of residents interviewed	8	Number of staff interviewed	8	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	8	Total number of managers (headcount)	3
Number of medication records reviewed	20	Total number of staff (headcount)	45	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

Declaration

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

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	Health Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Friday, 19 September 2014

Executive Summary of Audit

General Overview

Woodlands Lifecare is currently providing rest home and hospital level care in a 63 bed facility. The service provider has converted an existing 17 bed rest home wing in to a secure area that they are proposing to open in late October 2014. This audit is undertaken to establish the level of preparedness of the provider to provide this newly configured service. The facility is operated by Oceania Care Company Limited. Four areas were identified as requiring improvement during this audit relating to evidence the existing fire evacuation scheme remains approved by the New Zealand Fire Service, the safety of the external secure area, management of medicines including medication documentation and safe storage of medicines for a resident who self administers their own medicines.

Outcome 1.1: Consumer Rights

The business and care manager is responsible for the management of complaints and a complaints register is maintained. The residents can use the complaints forms, raise issues at the residents' meetings, or they can raise complaints directly with the business and care manager, the clinical manager, or with any member of staff. The area requiring improvement from the last audit relating to the complaints register has been addressed.

Outcome 1.2: Organisational Management

Oceania Care Company Limited is the governing body and is responsible for the service provided at Woodlands Lifecare. Planning documents reviewed include a vision statement, values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Woodlands Lifecare including regular monthly reporting by the business and care manager who was appointed in May 2014 to manage this facility. The business and care manager is supported by a clinical manager who is responsible for oversight of the clinical care provided.

There are policies and procedures on human resources management and the validation of current annual practicing certificates for personnel who require them to practise is occurring. In-service education is provided at least weekly for staff and staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Oceania education programme. A review of staff records provides evidence that human resource processes are being followed, orientations are being completed, competency assessments are completed (as appropriate) and individual education records are maintained. The area requiring improvement from the last audit relating to staff files has been addressed.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and currently consists of one registered nurse and two health care assistants. The business and care manager and the clinical manager share the after hours on call. Care staff interviewed report there is adequate staff available and that they are able to get through their work. The business and care manager has developed a staff roster that will be implemented in stages as residents are admitted to the proposed dementia unit.

Outcome 1.3: Continuum of Service Delivery

The service has a documented activities programme that is displayed and available for residents and relatives. The planned activities are appropriate to the group setting. The residents and family interviewed confirm satisfaction with the activities programme. The residents' files evidence individual activities are provided either within group settings or on a one-on-one basis and residents' meetings evidence residents' input into the activities programme. The previous area requiring improvement around activities has been met.

The staff responsible for medicine management have attended in-service education for medication management and have current medication competencies. The medicine charts sampled demonstrate residents' photo identification, medicine charts are legible, three monthly medicine reviews are conducted and discontinued medicines were dated and signed by the GP. There are two residents' who self-administer medicines.

There are areas requiring improvement around medication prescribing and residents' self-administration of medicines.

Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. The resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. The menu has been reviewed by a dietitian.

Outcome 1.4: Safe and Appropriate Environment

The reconfiguration of services at Woodlands Lifecare (Woodlands) consists of creating a secure dementia unit by refurbishing and converting an existing 17 bed rest home wing in to secure dementia unit. The conversion also includes separate service areas for the dementia unit including two lounges, a dining room, sluice room and a secure external area. Improvements are required to the secure external area as two areas are identified as potential climbing hazards.

All 17 bedrooms provide single accommodation and there are adequate toilet and shower facilities in this unit. Residents' rooms are large enough to allow for residents to safely move around in them. An appropriate call system is available and security systems are in place. This area currently has no residents in it and the service provider is proposing to use this area from late October 2014.

There are policies and procedures for waste management, cleaning, laundry and emergency management and these are known by staff. Staff receive training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities in all areas, safe storage of chemicals and equipment and that protective equipment and clothing is provided and is used by staff.

Outcome 2: Restraint Minimisation and Safe Practice

The service has an overarching risk and quality management system that demonstrates compliance with the standard. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are least restrictive. The facility is using three restraints and one enabler on audit day.

Residents' files sampled evidence resident and family input into the restraint approval process, restraint assessment and risk processes are being followed. Monitoring of restraint is occurring and each episode of restraint is being evaluated. Restraint committee meeting minutes evidence an approval review process.

Outcome 3: Infection Prevention and Control

The infection control policy meets the needs of the organisation and provides information and resources to inform the service providers on infection prevention and control. Interview with the infection control co-ordinator confirms there is an infection control co-ordinators' role with a position description.

The delegation of infection control matters throughout the organization is clearly documented. There is documented evidence the governing body receives regular reports on infection related issues by regular reporting systems. The infection control programme was last reviewed in February 2014.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	15	0	1	2	0	0
Criteria	0	35	0	0	4	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	32
Criteria	0	0	0	0	0	0	0	62

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		practice guidelines.				
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	Eleven of twenty medication charts evidence the PRN medication charted does not record specific target symptoms and instruction for the PRN medicine use.	Provide evidence of correct prescribing of the PRN medications.	90
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	One of two residents who self-administers complimentary medicines does not have these charted on their medication chart and the medicines are not safely stored.	Provide evidence of residents who self-administer medicines do so according to policy and the medication guides.	90
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.6	Consumers are provided with safe and accessible external areas that meet their needs.	PA Moderate	There are two areas that may pose a potential climbing hazard and security issues in the external dementia area.	Provide evidence of elimination of the potential climbing hazard and the security risk in the dementia outdoor area.	Prior to occupancy
HDS(C)S.2008	Standard 1.4.7:	Consumers receive an	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Essential, Emergency, And Security Systems	appropriate and timely response during emergency and security situations.				
HDS(C)S.2008	Criterion 1.4.7.3	Where required by legislation there is an approved evacuation plan.	PA Moderate	There is no documentation available from New Zealand Fire Service to indicate that the fire evacuation plan in June 2000 remains approved as a result of the installation of an electronic door and removal of fire extinguishers.	Provide documented evidence that New Zealand Fire Service have approved a fire evacuation scheme that includes the change of use to include a dementia unit.	Prior to occupancy

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

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

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

Attainment and Risk: FA

Evidence:

Criterion 1.1.13.3 was identified as requiring improvement during the last certification audit and has now been addressed.

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

The business and care manager advises there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. A clinical and quality manager from Oceania advises there has been one complaint made to the District Health Board (DHB) that the clinical and quality manager investigated. The clinical and quality manager advised during interview they have reported the findings of this investigation to the DHB. Documentation relating to this complaint is reviewed during this audit.

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

A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of the business and care manager's monthly reports provides evidence of reporting of complaints to the governing body and staff. Care staff interviewed confirm this information is reported to them via their staff meetings.

The District Health Board contract requirements are met

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Oceania Care Company Limited (Oceania) is the governing body and is responsible for the service provided at Woodlands Lifecare (Woodlands). The Oceania quality and risk management systems were implemented at Woodlands and the documented scope, direction, goals, vision, values, mission statement and philosophy are reviewed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

Systems for monitoring the service provided at Woodlands including regular monthly reporting by the business and care manager (BCM) and the clinical manager (CM) to Oceania support office via the Oceania intranet are in place. Reporting includes reporting on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators. Monthly business status reports are provided to the Oceania executive team and link to the organisations business plan.

The BCM was initially appointed to this position in January 2014 but took on another role within Oceania for a short period. The BCM assumed responsibility for the management of Woodlands on 26 May 2014. The BCM has extensive aged care experience as they have worked in the aged care sector for the last 21 years, the last eight years in management positions. The BCM is supported by a CM who is an experienced RN and who is responsible for the clinical care provided to residents with support from the BCM.

The BCM and CM are also supported by an Oceania clinical and quality manager as well as a regional business operations manager from Oceania. The BCM and CM have current practising certificates. The BCM and CMs and personal files are reviewed and there is documented evidence they attend education to keep themselves up-to-date.

Woodlands is currently certified to provide hospital and rest home level care. The governing body has contracts with the District Health Board (DHB) to provide aged related residential care (rest home and hospital), respite care, residential non-aged care, and community residential services for people who are chronically medically ill.

During this audit there are 25 residents assessed as requiring rest home level care and 13 residents assessed as requiring hospital level care. The area that was used for 17 rest home residents has been decommissioned and refurbished to accommodate 17 residents who are assessed as requiring dementia level care. The BCM advises they want to open this new unit in late October 2014.

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:

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 with support from the regional clinical and operations manager from Oceania. Twenty four registered nurse cover is provided.

Additional support and assistance is provided by other personnel from Oceania support office as required. Services provided meet the specific needs of the resident group within the facility. Job descriptions and interviews of the BCM and CM confirm 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 1.2.7: 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:

Criterion 1.2.7.3 was identified as requiring improvement during the last certification audit and has now been addressed.

A registered nurse (RN) is employed to oversee the inservice education programme provided at Woodlands and during interview they advise they usually spend six to eight hours a week in this role. The BCM and RN educator advise during interview that an annual education plan is developed that is based on the Oceania education plan and that in-service education sessions are provided at least once a week. They also advise that staff are supported to complete the New Zealand Qualifications Authority Unit Standards via the Oceania Certificates in Residential Care, National Certificate in Health, Disability and Aged Support, and National Certificate in Community Support Services and that the RN educator is an on-site verifier for this programme. The BCM advises that all staff who will be working in the dementia unit are currently working in the rest home and hospital areas. The BCM and RN educator advise that these health care assistants (HCAs) have completed education in challenging behaviour, de-escalation and restraint minimisation and this is confirmed during review of education records. Two of the eight HCAs who will be working in the dementia unit have already completed the dementia specific unit standards The RN educator advises that 16 of the HCAs and the RNs who have not already completed the dementia specific unit standards are enrolled and are currently working their way through these modules. They also advise they are required to complete these within six months.

Staff are required to attend the compulsory Oceania education sessions each year to progress through the Oceania career pathway programme. In-service education plans, staff competency registers and staff education records are maintained and are reviewed for 2014.

Staff are supported to complete an orientation programme that includes role specific learning modules.

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 (eight of eight) along with employment agreements, criminal vetting, completed orientations and competency assessments. Individual records of education are maintained for each staff member.

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

Three of three health care assistants (HCAs) interviewed working all areas (one will be working in the dementia unit) and two registered nurses (RNs) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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 (Interim Staffing Policy) for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum number of staff that is currently provided is during the night shift and consists of one registered nurse (RN) and two health care assistants (HCAs). A proposed roster and transition plan for staffing the new 17 bed dementia unit is reviewed that indicates on opening day there will be at least one HCA on each shift in the new unit. The transition plan states that when occupancy increases to seven in the new area and depending on resident acuity that a second HCA will be provided for three hours on the morning and afternoon shifts. This plan states that when resident numbers reach 11, an additional HCA will be provided on the morning and afternoon shifts. When the resident numbers get to 15 there will be a third HCA working for four to six hours on the morning shift. Twenty four hour registered nurse cover is provided at Woodlands

Care staff interviewed report there is adequate staff available and that they are able to get through the work allocated to them. Residents (four rest home and four hospital) and family members (two) 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 District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.7: 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:

An interview with the diversional therapist (DT) confirms the DT has been employed at the facility since May 2014. The service has a documented activities programme for the rest home and hospital that is displayed and available for residents and relatives, sighted. The DT confirms the activities programme meets the needs of the service group and the service has appropriate equipment. The DT is employed for 30 hours a week, Monday to Friday. An interview with the business and care manager confirms the service is currently advertising to fill a position for an activities co-ordinator to be employed for four hours a day, seven days a week and for this to commence once there are five residents residing in the proposed dementia unit.

The residents' activities attendance records are maintained and are sighted.

The six residents' files (three rest home and three hospital) sampled demonstrate the individual activities care plans are current, record individual interests identified for the residents and demonstrate support is provided within the areas of leisure and recreation, health and well-being.

Eight of eight residents (four rest home and four hospital) and two of two hospital residents' family interviewed confirm residents' past activities are considered and there is a choice to participate in activities. The residents, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.

The residents' meeting minutes are sighted for July and September 2014 and evidence the residents input into the activities programme. The September 2014 meeting minutes evidence discussion and information around the results of the menu and the residents' satisfaction survey.

There was an area identified requiring improvement at last audit relating to the availability of an activities programmes, appropriate activities and residents' input into the activity plans and this is found to be fully attained following this partial provisional audit.

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 1.3.12: 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:

There are two existing medication areas in the facility and they evidence an appropriate and secure medicine system, free from heat, moisture and light, with medicines stored in original dispensed packs. The clinical manager/ registered nurse (RN) states the medication area for the dementia unit will be located in the dementia unit office. The dementia unit office is a locked room with enough space for a medication trolley, sighted.

There is one controlled drug storage at the facility that is secure, located in the hospital medication/treatment room. The controlled drug register is maintained and evidences weekly checks and six monthly stocktakes. The medication fridge temperature checks are conducted and recorded. Sighted a medication fridge in the dementia unit office.

There are eight RNs, one enrolled nurse (EN) and eight health care assistants with current medication competencies, assessed as competent to administer medicines. The staff medication competencies are sighted in the staff files sampled and on the staff competency register, as are additional staff competencies in insulin administration, oxygen administration and nebuliser use. The staff education in medicine management was conducted in May 2014, by a pharmacist. Interviews with three of three health care assistants who administer medication confirm staff have received education in medication management and have conducted medication competencies. The staff and GP signature logs are recorded.

The rest home and the hospital lunch time medication rounds evidence staff are knowledgeable about the medicine administered and sign off, as the dose is administered. The medication errors are recorded and communicated to Oceania support office on monthly basis, confirmed by the clinical manager/RN and sighted on the Oceania intranet for March, April, May, June, July and August 2014. The clinical manager states staff are required to conduct repeat medication competencies following medication errors, sighted as occurring in the documentation reviewed and confirmed at staff interviews.

Twenty medicine charts (10 rest home and 10 hospital) are sampled and demonstrate residents' photo identification, medicine charts are legible, as required medication (PRN) is identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GP. The PRN medicines do not evidence indications for use in 11 out of 20 medication charts sighted and this requires an improvement.

There are two residents at the facility who self-administer medicines. The residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given) except for one resident who is self-administering complimentary medicines and these medicine also require safe storage, an area identified as requiring improvement.

Medication audits are conducted according to the internal audit schedule, sighted.

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 medication charts reviewed (10 rest home and 10 hospital). The residents' medication charts evidence residents' photo identification, medicine charts are legible, as required medication (PRN) is identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GP. The PRN medicines do not consistently evidence the indications for use.

Finding:

Eleven of twenty medication charts evidence the PRN medication charted does not record specific target symptoms and instruction for the PRN medicine use.

Corrective Action:

Provide evidence of correct prescribing of the PRN medications.

Timeframe (days): 90 (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: PA Moderate

Evidence:

There are two residents who self-administer medicines. There is a policy and procedure for residents who self-administer medicines.

Finding:

One of two residents who self-administers complimentary medicines does not have these charted on their medication chart and the medicines are not safely stored.

Corrective Action:

Provide evidence of residents who self-administer medicines do so according to policy and the medication guides.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The food service policies and procedures are appropriate to the service setting with a new seasonal menu being introduced six monthly. The menu was last reviewed by a dietitian in March 2014. The food is prepared and cooked on site. The lunch time food service is observed.

Visual inspection evidences the proposed dementia wing has a kitchenette for staff to be able to store and make snacks for residents.

The residents' dietary profiles are located in the kitchen for the kitchen staff's reference, sighted. A visual board in the kitchen records the residents' specific requirements such as food dislikes, food allergies and special diets. An interview with the kitchen manager confirms awareness of the residents' special diets and food allergies. The residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review, confirmed at RN interview and sighted in six of six resident files reviewed (three rest home and three hospital).

Six of six residents' files (three rest home and three hospital) reviewed in respect of the residents' dietary requirements (dietary profile reviews and dietary needs on care plans) evidence current records. There is evidence in all six resident files of monthly weight monitoring and additional nutritional and hydration assessments when, this is required.

The staff files of kitchen staff sampled evidence current food safety training and this is confirmed at the kitchen manager's interview and also sighted on staff training records.

The residents and family interviewed are satisfied with the food service provided, report residents' individual preferences are catered and adequate food and fluids are provided.

The food temperatures are recorded, sighted. The chiller and freezer are temperatures are recorded and decanted food is dated, sighted.

A menu/food satisfaction survey was last conducted in July 2014, with meal service response at a satisfactory level. The survey results have been communicated to the residents at their meeting in September 2014, sighted in residents' meeting minutes.

A kitchen services audit was conducted in April 2014, with corrective actions addressed.

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. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available and are reviewed in the sluice rooms and cleaners area. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided in August 2014. 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 the cleaning and laundry processes in place at Woodlands. All laundry services are provided from Whareama which is another Oceania facility in Nelson.

Sluice facilities are available in each area, including a sluice room in the dementia wing. A visual inspection of all four wings provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and are being used by staff. For example, face shields, gloves, aprons, footwear and masks are viewed in the sluice rooms, soiled laundry storage area and in the cleaners' room.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled and the container is appropriate for the contents including container type, strength and type of lid/opening.

The District Health Board contract requirement is 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: PA Low

Evidence:

There are two maintenance staff employed at the facility for a total of 52 hours a week. The maintenance person interview confirms there are preventative and reactive maintenance programmes in place and regular building inspections are conducted according to the owner's inspection and maintenance records for the building warrant of fitness requirements, sighted. The preventative maintenance plan includes external areas and equipment. The medical equipment checks were conducted by an external contractor in August 2014. There is safe storage of medical equipment, sighted. The Building Warrant of Fitness expires 31 March 2015.

In the proposed dementia unit all residents' bedrooms are of single occupancy. The communal facilities are home-like and comfortable. The dementia unit has space to allow for freedom of movement internally and multiple accesses to an external area. The corridors are wide enough to allow residents to pass each other safely. The safety rails are secure and are appropriately located. The floor surfaces/coverings are appropriate to the resident group and setting.

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 was confirmed at five of five clinical staff interviews (two RNs and three health care assistants) and evidenced in the review of staff education records and staff files.

There is an area requiring improvement around the external area in the dementia unit.

The District Health Board contract requirements are not fully 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: PA Moderate

Evidence:

The external area adjoining the dementia unit has multiple accesses from the unit and there is seating and shade. The dementia external area is surrounded by a security fence with two gates with key pad locks. The gardens in the dementia outdoor area are in the process of being completed. The dementia outdoor area has hand rails with wire mesh located by ramps and pathways. The business and care manager states these existing handrails are to be replaced with standard hand rails and posts without mesh (sighted a photograph of the proposed rails). The visual observation evidences two areas in the dementia outdoor area that may pose a potential climbing hazard and security issues.

There are two areas in the dementia outdoor area that are potential climbing hazards. The first area adjacent to the maintenance shed has a handrail in place that is approximately 750 mm high, creating a potential climbing hazard. There may be a potential for a resident to climb to approximately 600mm to the first footing on the security fence and then another 100mm for a second footing to be able to get over the security fence.

The second area is close to the entry to the external dementia area from the dementia dining room. This area is located next to the rest home external area. The potential climbing hazard and security risk is the same as in the first area.

Finding:

There are two areas that may pose a potential climbing hazard and security issues in the external dementia area.

Corrective Action:

Provide evidence of elimination of the potential climbing hazard and the security risk in the dementia outdoor area.

Timeframe (days): Prior to occupancy (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:

The living, dining, bathing, toilet and outdoor areas of the proposed dementia unit are separate from the rest home and hospital residents' residing at the facility. All bedrooms in the hospital, rest home and the dementia unit (except one hospital bedroom with full ensuite) provide single accommodation and all have hand basins. There is adequate number of communal toilet and shower facilities in the facility. The bathroom facilities are of an appropriate design and number 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, confirmed at interview with the maintenance person and sighted records of hot water monitoring.

All toilets have appropriate access for residents and are clearly identified. Communal bathroom facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in these areas. There are additional toilet facilities for visitors and staff.

There are three sluice rooms located at the facility and the proposed dementia wing has secure access to one sluice room.

The District Health Board contract requirement is 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:

The proposed dementia wing has resident's bedrooms with single occupancy only. Visual inspection evidences that adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely.

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

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: <p>There are four small lounges and two large lounges at the facility. The four small lounges are in each of the wings of the facility (hospital, rest home, dementia and dual share bed wings). One of the two large lounges is used by residents in the rest home and hospital and the second large lounge is located in the dementia wing. Visual inspection evidences adequate access is provided to the lounges and appropriate seating for residents is provided.</p> <p>There are three dining rooms at the facility, one for hospital residents, second for rest home residents and third for the dementia residents. There is adequate seating to provide dining needs for all residents at the facility. The internal physical environment of the proposed dementia unit is suitable for dementia level residents and allows for freedom of movement.</p> <p>The District Health Board contract requirement is met.</p>

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:

Cleaning policy and procedures and laundry policy and procedures are available as well as policies and procedures for the safe storage and use of chemicals / poisons.

All laundry is washed at Whareama which is another Oceania facility in Nelson. Soiled linen is stored appropriately until it is transported in a truck to Whareama for washing. Soiled linen is currently being collected daily. There is adequate dirty / clean flow in the existing laundry and personnel interviewed describe the management of laundry including transportation, sorting, storage, laundering, and return to residents. Clean linen is stored in a linen room and is stocked up daily from the laundry.

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. Completed audits for the laundry and cleaning are reviewed during this audit. Cleaning staff are interviewed and they describe the management of the cleaning processes including the use of personal protective equipment.

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 as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.

Relatives interviewed state they are satisfied with the cleaning and laundry service. This finding is confirmed during review of collated results for the family / resident satisfaction surveys completed in July 2014.

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: PA Moderate

Evidence:

An area requiring improvement has been identified during this audit relating to the status of the fire evacuation scheme that was approved by New Zealand Fire Service on 27 June 2000 (see criterion 1.4.7.3). The last trial evacuation was held on 30 June 2014.

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

Registered nurses, diversional therapists and personnel who drive the van with residents in it are required to complete first aid training. There are at least two designated staff members on each shift with appropriate first aid training and review of a roster confirms this. A competency spreadsheet is reviewed and the registered nurses, one diversional therapist and several health care assistants have current first aid certificates. All staff are given an opportunity to complete first aid training as it is part of the Oceania career pathway.

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

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

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

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

A call bell system is in place and is used to summon assistance if required. Sensor mats are also used in some resident's bedrooms. Call bells are accessible / within reach, and are available in resident areas (e.g. bedrooms, ablution areas, ensuite toilet/showers).

Not all of the District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: PA Moderate

Evidence:

The business and care manager (BCM) advises during interview that the project manager has advised them that the existing fire evacuation scheme remains unchanged as result of this reconfiguration of services to convert 17 existing rest home beds in to a 17 bed secure dementia unit. The BCM advises there have not been any alterations to the existing fire cells but that an electronic lock has been installed onto a door to make the unit secure. They also advise that the lock is connected to the fire system and will unlock if the fire alarms are activated. This is confirmed during review of documentation between the building project manager and the local district council. The BCM also advises during interview that the fire extinguishers have been removed from the dementia unit.

Finding:

There is no documentation available from New Zealand Fire Service to indicate that the fire evacuation plan in June 2000 remains approved as a result of the installation of an electronic door and removal of fire extinguishers.

Corrective Action:

Provide documented evidence that New Zealand Fire Service have approved a fire evacuation scheme that includes the change of use to include a dementia unit.

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

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

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

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

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:

Visual inspection evidences each room is provided with adequate natural light. Ventilation is by opening windows and doors. The environment is maintained at comfortable temperature. Management state there are no residents who smoke at the facility.

Residents and family interviewed confirm the facility (existing units) are maintained at an appropriate temperature.

The District Health Board contract requirement is 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:

Documented systems are in place to ensure the use of restraint is actively minimised and the use of least restrictive practices are encouraged where required.

Interview with the clinical manager (RN) / restraint co-ordinator confirms there are three restraints and one enabler used at the facility on audit day. This is recorded on the restraint register and confirmed at clinical staff interviews. The restraint minimisation meeting occur two monthly, meeting minutes sighted. Review of the residents' files using restraints and an enabler evidences all processes are followed.

The service has an overarching risk and quality management system that demonstrates compliance with the restraint standard. The process of assessment and evaluation of enabler use is documented in policies and procedures to guide staff. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.

Staff education programme on restraint /enabler was conducted in February 2014 and staff education on dementia care and challenging behaviour management was conducted in August 2014. Interview with three of three health care assistants (HCA) confirm education has been provided in dementia care, two of three HCA have completed dementia education/ training and the third HCA is near completion of the required training in dementia care.

Restraint use audit was conducted in July 2014 with 100% compliance.

Staff competency register records restraint competencies for all clinical and non-clinical staff are current.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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:

The infection control (IC) policy meets the needs of the organisation and provides information and resources to inform the service providers on infection prevention and control, confirmed at staff interviews. Interview with the clinical manager/RN /infection control co-ordinator (ICC) is conducted and confirms infection control processes are followed at the facility.

The delegation of infection control matters throughout the organization is clearly documented along with an ICC job description, sighted. There is documented evidence the governing body receives regular reports on infection related issues by regular reporting systems, sighted on the Oceania intranet. The IC programme is reviewed annually.

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.

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

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

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 3.1.9 (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.

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: Not Audited

Evidence:

Finding:

Corrective Action:

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

