Oceania Care Company Limited - Elmwood Village

Current Status: 4 September 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

Elmwood Village can provide care for up to 142 residents. During the certification audit there were 132 residents living at the facility including 52 residents at the rest home level of care and 80 residents at hospital level of care. The business and care manager was responsible for the overall management of the facility and had been in the role since 2008.

Service delivery was monitored through a quality and risk management programme that included review of complaints, incidents and accidents, surveillance of infections, completion of internal audits, clinical indicator review and satisfaction surveys.

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

Improvements are required to the complaints system, maintenance checks, the call bell system, documentation of pain management, documentation of short-term care plans and medication management.

Audit Summary as at 4 September 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

Indicator	Description	Definition
	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 4 September 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 low risk.

Organisational Management as at 4 September 2014

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

Continuum of Service Delivery as at 4 September 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 4 September 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.		Some standards applicable to this service partially attained and of low risk.

Restraint Minimisation and Safe Practice as at 4 September 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 4 September 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 4 September 2014

Consumer Rights

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

An improvement is required to the complaints system including documentation of responses with copies of correspondence to the complainant kept on file.

Organisational Management

Elmwood Village has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. Quality and risk performance is reported across the facility meetings and monitored by the organisation's management team through the business status reports. Quality improvement occurs through review of incidents, accidents, complaints, implementation of an internal audit schedule, benchmarking and a health and safety programme.

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

The business and care manager has extensive experience in aged care and in facility management roles. There are two clinical managers who provide clinical oversight. All are supported by the Oceania clinical and quality manager and operations manager who have extensive knowledge and experience in aged care.

Continuum of Service Delivery

The resident's entry in to the services is facilitated in a competent, equitable, timely, and respectful manner. All residents have appropriate needs assessments. Each stage of assessment, planning, provision of care and review/evaluation is undertaken by suitably qualified staff with current practising certificates. The registered nurses conduct the initial assessment using standardised risk assessment tools. An information pack is provided to the resident/families on admission.

Admission agreements are signed on admission by the residents or their families. The potential residents are recorded in the enquiry book. Declined residents are referred back to the referrer in a timely manner.

The service has an integrated system of documentation. The general practitioner (GP) admitted new residents within 24-48 hours and conducted three monthly reviews or more as required. Person centred care plans were reviewed three monthly. Multi-disciplinary reviews are conducted annually. Activities provided by the service are appropriate to the needs of the residents. The contents of the verbal hand-over between shifts are comprehensive. Progress notes are maintained and the levels of documentation by the staff reflect the care provided during the shifts.

Referrals are made to specialist medical services as well as other allied health professionals. There are policies and procedures for transition, exit, discharge or transfer of residents. Yellow envelopes are utilised.

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, storage, disposal, and medicine reconciliation in order to comply with legislation, protocol, and guidelines. Improvements are required in relation to transcribing of medications. There is one resident who self-administers medicines. There is a self-administration policy and procedures in place.

A dietary requirement form is completed on admission that guides the care staff and the cook. There are diet codes in the kitchen. Modified diets are provided by the service. Food handling certificates are all current. The winter and summer menus are reviewed annually by the dietitian. Food temperatures and fridge/freezer/chiller temperatures are monitored daily. Staff are using clean technique in food preparation. Cleaning is conducted daily in the kitchen.

Safe and Appropriate Environment

All building and plant comply to legislation with comprehensive fire safety checks by an external contractor. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Laundry is completed on site for three facilities and the managers and staff monitor cleaning to ensure that the facility is clean at all times.

Essential emergency and security systems are in place with regular fire drills completed.

Improvements are required to ensuring that maintenance checks are completed as per schedule and to completion of the installation of the new call bell system.

Restraint Minimisation and Safe Practice

The restraint minimisation and safe practice policy and procedure are implemented by the service. The restraint register is current and there are three residents on restraint. Restraint assessments, restraint consents and restraint monitoring forms are evidence. Risk management plans are in place for all three residents on restraint and three monthly evaluations are evidence. Restraint minimisation and safe practice is encouraged. The hospital clinical manager is the restraint coordinator. Staff demonstrate good knowledge about restraints and enablers. All staff have current restraint competencies. Restraint in-service educations are completed annually while the restraint minimisation policy and procedures are also reviewed annually.

Infection Prevention and Control

The infection control programme is appropriate to the size and scope of the service and was reviewed last annually. The infection control coordinators can access resources both within and outside the organisation. Staff are knowledgeable about infection control and prevention. The infection control committee has representatives from different areas within the service and conducts monthly meetings. In-service training is provided regularly for all staff.

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 - Elmwood Village

Designated Auditing Agency:	Health Audit (NZ) Limited

Types of audit:	Certification Audit		
Premises audited:	Elmwood Village		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
Dates of audit:	**Start date:** 4 September 2014	**End date:** 5 September 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:	132

Audit Team

Lead Auditor	Tricia Doré	**Hours on site**	16	**Hours off site**	8
Other Auditors	Arby Manalansan	**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	Joy Hickling			**Hours**	3.5

Sample Totals

Total audit hours on site	32	Total audit hours off site	15.5	Total audit hours	47.5

Number of residents interviewed	12	Number of staff interviewed	20	Number of managers interviewed	5
Number of residents' records reviewed	13	Number of staff records reviewed	12	Total number of managers (headcount)	5
Number of medication records reviewed	24	Total number of staff (headcount)	132	Number of relatives interviewed	10
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, Majid Zahoor , 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, 15 September 2014

Executive Summary of Audit

General Overview

Elmwood Village can provide care for up to 142 residents. During the certification audit there were 132 residents living at the facility including 52 residents at the rest home level of care and 80 residents at hospital level of care. The business and care manager was responsible for the overall management of the facility and had been in the role since 2008.

Service delivery was monitored through a quality and risk management programme that included review of complaints, incidents and accidents, surveillance of infections, completion of internal audits, clinical indicator review and satisfaction surveys.

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

Improvements are required to the complaints system, maintenance checks, the call bell system, documentation of pain management, documentation of short-term care plans and medication management.

Outcome 1.1: Consumer Rights

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

An improvement is required to the complaints system including documentation of responses with copies of correspondence to the complainant kept on file.

Outcome 1.2: Organisational Management

Elmwood Village has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. Quality and risk performance is reported across the facility meetings and monitored by the organisation's management team through the business status reports. Quality improvement occurs through review of incidents, accidents, complaints, implementation of an internal audit schedule, benchmarking and a health and safety programme.

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

The business and care manager has extensive experience in aged care and in facility management roles. There are two clinical managers who provide clinical oversight. All are supported by the Oceania clinical and quality manager and operations manager who have extensive knowledge and experience in aged care.

Outcome 1.3: Continuum of Service Delivery

The resident's entry in to the services is facilitated in a competent, equitable, timely, and respectful manner. All residents have appropriate needs assessments. Each stage of assessment, planning, provision of care and review/evaluation is undertaken by suitably qualified staff with current practising certificates. The registered nurses conduct the initial assessment using standardised risk assessment tools. An information pack is provided to the resident/families on admission. Admission agreements are signed on admission by the residents or their families. The potential residents are recorded in the enquiry book. Declined residents are referred back to the referrer in a timely manner.

The service has an integrated system of documentation. The general practitioner (GP) admitted new residents within 24-48 hours and conducted three monthly reviews or more as required. Person centred care plans were reviewed three monthly. Multi-disciplinary reviews are conducted annually. Activities provided by the service are appropriate to the needs of the residents. The contents of the verbal hand-over between shifts are comprehensive. Progress notes are maintained and the levels of documentation by the staff reflect the care provided during the shifts.

Referrals are made to specialist medical services as well as other allied health professionals. There are policies and procedures for transition, exit, discharge or transfer of residents. Yellow envelopes are utilised.

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, storage, disposal, and medicine reconciliation in order to comply with legislation, protocol, and guidelines. Improvements are required in relation to transcribing of medications. There is one resident who self-administers medicines. There is a self-administration policy and procedures in place.

A dietary requirement form is completed on admission that guides the care staff and the cook. There are diet codes in the kitchen. Modified diets are provided by the service. Food handling certificates are all current. The winter and summer menus are reviewed annually by the dietitian. Food temperatures and fridge/freezer/chiller temperatures are monitored daily. Staff are using clean technique in food preparation. Cleaning is conducted daily in the kitchen.

Outcome 1.4: Safe and Appropriate Environment

All building and plant comply to legislation with comprehensive fire safety checks by an external contractor. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Laundry is completed on site for three facilities and the managers and staff monitor cleaning to ensure that the facility is clean at all times.

Essential emergency and security systems are in place with regular fire drills completed.

Improvements are required to ensuring that maintenance checks are completed as per schedule and to completion of the installation of the new call bell system.

Outcome 2: Restraint Minimisation and Safe Practice

The restraint minimisation and safe practice policy and procedure are implemented by the service. The restraint register is current and there are three residents on restraint. Restraint assessments, restraint consents and restraint monitoring forms are evidence. Risk management plans are in place for all three residents on restraint and three monthly evaluations are evidence. Restraint minimisation and safe practice is encouraged. The hospital clinical manager is the restraint coordinator. Staff demonstrate good knowledge about restraints and enablers. All staff have current restraint competencies. Restraint in-service educations are completed annually while the restraint minimisation policy and procedures are also reviewed annually.

Outcome 3: Infection Prevention and Control

The infection control programme is appropriate to the size and scope of the service and was reviewed last annually. The infection control coordinators can access resources both within and outside the organisation. Staff are knowledgeable about infection control and prevention. The infection control committee has representatives from different areas within the service and conducts monthly meetings. In-service training is provided regularly for all staff.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	44	0	3	3	0	0
Criteria	0	96	0	3	2	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 1.1.13: Complaints Management	The right of the consumer to make a complaint is	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		understood, respected, and upheld.				
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	Three staff members have documented evidence in response to complaints however, while there is a signature and name, there is no designation included that would therefore identify them as staff. Ii) In two of the six complaints, there is confirmation that the issues are resolved however letters to the complainants are not kept on file to confirm that the complainant has their complaint acknowledged or the complaint resolved.	Ensure that any staff member documenting evidence in response to the complaint includes their designation. Ii) Retain letters to the complainants on file to confirm that the complainant has their complaint acknowledged or the complaint resolved.	180
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Moderate			
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or	PA Moderate	The PCCPs of the three reviewed resident’s files do not	The PCCPs must reflect pain issues when residents are	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		intervention to achieve the desired outcomes identified by the ongoing assessment process.		reflect issues around pain management although these residents are receiving regular controlled drugs. Short term care plans are not developed when residents are identified with gastroenteritis as part of the August 2014 outbreak. The pain status of the resident is not reflected in the PCCP of the hospital unit resident for tracer methodology. Staff do not recognise that the resident's increase in agitation following the fall could be a sign of possible fracture that requires immediate intervention.	receiving regular controlled drugs. Short term care plans must be developed for all acute infections. All staff must have adequate assessment knowledge, skills and training in relation to pain assessment and pain management. All PCCPs must reflect the pain status of the residents when present.	
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.6	Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with	PA Moderate	Out of 24 medication charts reviewed, there are five medications written in the non-packed medication signing sheets that show transcribing practices by the staff. This includes	All staff administering medications must not transcribe medications. Service to provide training for all staff in relation to medicine management, specifically on	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		legislation and guidelines.		medications that are administered via injection or taken orally.	transcribing.	
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 1.4.2.4	The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	The monthly maintenance checks have not routinely been completed in the first half of 2014 as per policy.	Ensure that monthly maintenance checks are completed as per policy.	180
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			
HDS(C)S.2008	Criterion 1.4.7.5	An appropriate 'call system' is available to summon assistance when required.	PA Low	There are times in some areas where the call bell system becomes overloaded and not all calls are displayed.	Complete the installation of the new call bell system.	180

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:

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

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

The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information.

Training around the code of rights, privacy and confidentiality and complaints was last provided in February and September 2014. The auditors noted respectful attitudes towards residents on the day of the audit.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

A registered nurse discusses the Code (may include the business and care manager and/or clinical managers), including the complaints process with residents and their family on admission. Discussions relating to the Code are also held at during the monthly residents' meetings (meeting minutes sighted).

Residents and family interviewed including 12 residents (six rest home and six hospital) and 10 family members (four rest home and six hospital) confirm their rights are being upheld by the service.

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

Twelve residents and 10 family members interviewed are able to describe their rights and advocacy services particularly in relation to the complaints process. Eleven of the twelve family members interviewed confirm that they know where the complaints forms are (at the main entrance).

An audit of the Code and advocacy in June 2014 shows that the audit achieved 100%.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a philosophy that promotes dignity and respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values with the registered nurses and two clinical managers interviewed stating that the care plans are completed with the resident and family member (confirmed by residents and family interviewed). The 2014 satisfaction survey reports that 100% of respondents state that they are involved in the care planning process.

Interventions to support these are identified and evaluated. Residents are addressed by their preferred name and this is documented in 13 of 13 resident files reviewed (six rest home and seven hospital).

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

The service ensures that each resident has the right to privacy and dignity, which is recognised and respected. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room with a number of small areas and rooms available for family and residents to meet in each area. There is a large whanau room which can be used by any resident and family at end of life. This includes a kitchenette and space for family to stay overnight.

Seven of seven health care assistants interviewed report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirm the residents' privacy is respected with 100% identifying that they are satisfied or very satisfied with management of privacy and confidentiality.

Health care assistants interviewed report that they encourage the residents' independence by encouraging them to be as active as possible. A physiotherapist is available for three hours a day, five days a week to assess and review residents with a physiotherapist assistant supporting residents on weekdays. Health care assistants assist residents with their activity programmes.

The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. They are committed to provide guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the organisation's mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code as stated by the two clinical managers and the business and care manager. Staff receive mandatory education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation. Staff interviewed are aware of the signs of abuse and neglect and have last had annual training in December 2013.

Resident files reviewed (13 of 13) identifies that cultural and /or spiritual values, individual preferences are identified as per individual needs. There are Anglican services two times a week with Roman Catholic services weekly. The 2014 resident and family satisfaction survey noted that most respondents are satisfied or very satisfied with spiritual support provided with three residents/family stating that they would like the chaplain who used to visit the service to return.

There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.

Residents and family interviewed including 12 residents (six rest home and six hospital) and 10 family members (four rest home and six hospital) confirm that personal dignity and respect is respected and there is no evidence of bullying from staff or of any abuse or neglect. One family member raised an issue relating to incorrect information being given to the family after a significant incident in 2011 however the family did not wish to pursue this and states that despite this, they are confident that there is sound information provided and 'very good care' provided.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

Links to local kaumatua Maori services are documented with a kaumatua offering support when required up until three weeks ago. The kaumatua is no longer able to provide the service and the business and care manager is looking at linking into other kaumatua in the area currently.

There are eight residents who identify as Maori living at the facility during this certification audit. There are 40 staff members who identify as Maori. Staff describe talking with residents in te reo Maori to residents as per their communication needs. Staff interviewed report specific cultural needs are identified in the residents' care plans and all Maori residents have a cultural assessment completed (sighted in eight of eight files of Maori residents).

Staff are aware of the importance of whanau in the delivery of care for their residents who identify as Maori and staff interviewed can describe ways that they meet cultural needs.

Maori events are linked to the activities programme with a Waitangi Day celebration held with photographs of residents actively engaged in waiata and poi.

Staff have had training around cultural safety and Maori health in April 2014 and August 2014.

The District Health Board requirements are met.

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

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

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

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

Two family members of an Asian resident state that staff go out of their way to communicate with their relative despite English being a second language for the resident.

The 2014 resident and family satisfaction survey indicates 100% satisfaction with cultural needs of residents.

Staff have had training around cultural safety in April 2014 and August 2014.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

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

Job descriptions include responsibilities of the position, ethics, advocacy and legal issues with a job description sighted on 12 of 12 staff files reviewed.

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

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

Family and visitors are encouraged to visit residents and 10 relatives state that the service provides a welcoming and supportive environment.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

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

There is a comprehensive training programme and managers complete management training. The staff interviewed including the seven health care assistants describe sound practice based on policies and procedures, care plans and information given to them via the registered nurses, clinical managers and the business and care manager. Health care assistants interviewed state that over the last two years, there has been an increased emphasis on working to the policies, putting procedures and processes in place that are consistently applied, team work and supporting new staff and bureau staff with an experienced health care assistant at all times.

Specialised training and related competencies are in place for the registered nursing staff and for health care assistants.

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

All residents and families interviewed express a high level of satisfaction with the care delivered. One family was making a complaint to the business and care manager on the day of the audit but wanted the auditor to know that they still had a great deal of confidence in the organisation to continue to provide a high quality of care. They also state that they felt that they have confidence that their complaint will be heard and issues resolved in a timely manner.

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

The 2014 resident/family satisfaction survey indicates that all respondents bar one are satisfied or very satisfied overall with the service.

The District Health Board requirements are met.

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

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

Attainment and Risk: 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; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

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

Family contact is recorded in residents' files – sighted in 13 of 13 files reviewed.

Interviews with 10 family members (four rest home, six hospital) confirm they are kept informed. Family also confirm that they are invited at least six monthly to the care planning meetings/MDT (multi-disciplinary team meetings) for their family member.

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

Interpreter services are available when required from the District Health Board and the staff use family members to interpret when needed. Staff also interpret and communicate with family on a day to day basis with staff identifying as having a range of ethnicities/language including Fijian, Indian, Samoan, Chinese, South African. There are three residents who do not speak English and all have either family engaged daily with the family and/or have staff on site who can speak with and interpret for the resident. The business and care manager can cite the use of an interpreter in 2013 for one resident requiring this.

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

Staff have had training around communication in March 2014.

A review of 13 files indicates that all have a documented communication form that informs staff of family engagement with the service.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents and their families are provided with all relevant information on admission.
Discussions are held regarding informed consent, choice and options regarding clinical and non-clinical services.
Informed consent obtained includes the following: consent for sharing of information, consent for care and treatment, indemnity and outing consent. There is a consent for non-routine treatment or procedure completed e.g. for the flu injection.
There are advance directives documented if the resident is deemed competent.
Admission agreements sighted have all been signed on the day of admission.
Discussions with residents and relatives identify that the service actively involves them in decisions that affect their lives.
The District Health Board requirements are met.

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

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

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: 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 1.1.10.7 (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:

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

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

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

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

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

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

Ten families interviewed confirm they can visit at any reasonable time and are always made to feel welcome. Family were seen coming and going freely on the days of the audit.

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

Communication with family members is recorded on incident forms (20 of 20 sighted), communication forms on resident files and in progress notes.

The District Health Board requirements are met.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

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

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

Three complaints lodged with external authorities (i.e. two with the Health and Disability Commissioner dated March 2014 and July 2013 and two complaints by the same complainant lodged with a number of authorities dated initially in July 2014) are reviewed. There is documented evidence of time frames being met for responding to these complaints. One complaint has been followed with an audit by the Ministry of Health HealthCERT with the provider in the process of responding to any follow up identified as per timeframes in the report. All complaints lodged with the Health and Disability Commissioner, any other authorities have been extensively investigated by the business and care manager with the support of the clinical and quality and operations managers, and the provider is waiting for a response from authorities for all complaints.

Six complaints documented in 2014 are also reviewed. All are documented on the complaints register with all signed off stating that they are resolved. An improvement is required to ensure that any staff member documenting evidence in response to the complaint includes their designation and that any letters to the complainants are kept on file to confirm that the complainant has their complaint acknowledged or the complaint resolved (two of the six files did not include the documentation).

Twelve residents (six rest home and six hospital) and 10 family members (four rest home and six hospital) state that they would feel comfortable complaining. One family member states that a complaint had been made and this has been addressed through discussions with the business and care manager.

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

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

The District Health Board requirements are partially 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 service has had four complaints that have been filed with external authorities. The provider is waiting for sign off for these by relevant authorities. In the meantime, all have been extensively reviewed.

Six complaints documented in 2014 are also reviewed. All are documented on the complaints register with all signed off stating that they are resolved.

Finding:

i) Three staff members have documented evidence in response to complaints however, while there is a signature and name, there is no designation included that would therefore identify them as staff. Ii) In two of the six complaints, there is confirmation that the issues are resolved however letters to the complainants are not kept on file to confirm that the complainant has their complaint acknowledged or the complaint resolved.

Corrective Action:

i) Ensure that any staff member documenting evidence in response to the complaint includes their designation. Ii) Retain letters to the complainants on file to confirm that the complainant has their complaint acknowledged or the complaint resolved.

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:

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

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

The facility can provide care for up to 142 residents (53 rest home specific beds and 89 hospital beds with 25 beds included as dual purpose beds identified as assisted living suites). During the audit there are 132 residents living at the facility including 52 residents at the rest home level of care and 80 residents at hospital level of care. There are no residents using a medical level of care.

The business and care manager is responsible for the overall management of the facility and has been in the role since 2008. The business and care manager is a registered nurse. There is support from two clinical managers.

The business and care manager is supported by the operations manager and the clinical and quality manager who has a bachelor of science with a speciality practice in nursing (UK), has been working in aged care for over 20 years including 12 years aged care management in New Zealand. The operations manager is a registered nurse who has been at Oceania for over eight years.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In the absence of business and care manager, the clinical managers are in charge with support from the clinical and quality manager and operations manager. The current clinical managers are both registered nurses with a current annual practicing certificate.

The clinical and quality manager and operations manager are both on site on a weekly basis.

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: FA

Evidence:

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

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

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

All staff interviewed including seven health care assistants, the diversional therapist, four registered nurses, the kitchen manager and cook, team leader laundry services, charge nurse, one enrolled nurse and the business and care manager report they are kept informed of quality improvements.

There are annual family and resident satisfaction surveys which last took place in 2013 and 2014. The overall level of satisfaction rate of residents and families is satisfactory to very satisfactory with improvements made following recommendations made in the 2013 satisfaction survey. The 2014 action plan is currently being documented. There is also an annual food satisfaction survey with a corrective action plan already documented in June 2014 for the relevant survey.

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

The organisation holds a current ACC Work Safety and Management Practice tertiary level accreditation to March 2015 with six monthly ACC health and safety management plan reviews and action plans documented.

There is extensive monitoring of the service that includes the following: monitoring of complaints, incidents, accidents, health and safety, hazards etc. There is a business status report and a dashboard that informs Oceania and the service of progress against all quadrants e.g. financial, service delivery, customer

service, staffing. The service benchmarks against other similar services in Oceania. All aspects of the quality and risk management are discussed at relevant meetings with data and commentary escalated to head office through the monthly indicator reports. There are monthly meetings held across the service including quality, staff, infection control, resident/family, restraint and regular meetings for each group of staff e.g. registered nurse, head of department. There are monthly meetings around specific aspects of care i.e. weight management, falls management and management of wounds. All aspects of the quality and risk management programme are discussed through the meetings with significant evidence that improvements are made as a result of data collected and analysed.

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

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There has been an outbreak in August 2014 and relevant authorities are notified including public health and District Health Board.

The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the clinical manager, business and care manager and clinical and quality manager. The monthly staff awards have focused on documentation of any potential incident as a way of improving service delivery.

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

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

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

All 20 incidents are signed off appropriately by the clinical manager and/or the business and care manager

The District Health Board contract requirements are met.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

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

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract. Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency and the staff interviewed state that they buddy any new staff member or bureau staff throughout the shift.

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

The organisation has a mandatory education and training programme with sessions held monthly. Staff attendances are documented and there is evidence of good staff attendance as sighted on 12 files of staff who had attended 2013 training. Attendance records are also retained. The seven health care assistants state that they value the training. Education and training hours exceed eight hours a year.

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:

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy (132 residents currently in the service).

The facility is divided into four areas (hospital – 30 residents of 33 potential beds; Kauri wing which has 25 assisted living suites with a mix of 11 rest home and 14 hospital residents; rest home including 40 residents of a potential 42 beds and hospital area with 33 or a potential 37 residents).

There are two registered nurses on in the morning, afternoon and nights in the two hospital areas and one registered nurse in the rest home Monday to Friday (enrolled nurse over the weekend) and one registered nurse in Kauri unit from 7am-10.30pm.

There are health care assistants assigned to each area relevant to the needs of the residents and as per the staffing policy.

The business and care manager works full-time Monday – Friday and the clinical managers (registered nurses) work full-time with cover over seven days a week.

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

There are currently 132 staff including the business and care manager, two clinical managers, 16 registered nurses, three enrolled nurses, diversional therapist and three activities assistants, maintenance staff, laundry and cleaning staff seven days a week, mobility therapist, contracted physiotherapist for two hours day/ five days a week and 75 health care assistants.

The assisted living suite (Kauri unit) has a mix of residents requiring rest home and hospital level care. There is a nurse's station in the middle and at the end of the unit. Staff overnight stay in the unit to support 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:

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

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

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

Resident files are protected from unauthorised access by being locked away in an office. Informed consent is obtained from residents/family/whanau on

admission to display photographs. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

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

The District Health Board contract requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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:

The clinical manager (CM) reports that all residents coming to their service have the appropriate needs assessments prior entry to the service. A welcome pack is sighted which contains information about the service including the service provided, admission agreements, informed consents and haircut charges, The registered nurses (RNs) admit residents to the service using standard assessment tools.

All enquiries both telephone and walk-ins are evidence in the enquiry register.

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:

When residents entry to the service is declined, the business and care manager (BCM) or CM refers the resident back to the referrer as sighted in the enquiry register. The family/resident/resident are also informed about other alternative services within the organisation or nearby services who can offer them the appropriate service they require. The CM reports that they accept residents based on the level of care they provided (rest home, hospital, respite) and inform them the reason why the entry is declined and this is evidenced in the enquiry register.

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: PA Moderate

Evidence:

The residents receive timely, competent, and appropriate services that meet their assessed needs and desired outcome/goals. The registered nurses, physiotherapist, diversional therapist, general practitioner (GP) and pharmacists have current practising certificates sighted. New residents are admitted by the GP within 24-48 hours. The RNs develop the initial person centred care plan (PCCP) on admission that serves as a guide for all staff. The RNs utilise standardised assessment tools like RN assessment, cognitive, mobility, dietary, nutrition/hydration, continence, oral, pressure risk, gait/balance, oral, recreation, depression and cultural. Pain assessments are not completed but are not consistently reflected in the PCCP. This is an area for improvement in 1.3.5.2. Short term care plans are not consistently developed when acute conditions are identified. The example is when the service had an outbreak of infection on August 2014. Refer to 1.3.5.2. Short term care plans for infections in the urinary tract, respiratory tract, gastrointestinal tract, skin/soft tissue, eyes/ears/throat are evidence in all 13 reviewed resident's files. The resident's response to the treatment and the date resolved are documented in the sighted short term care plans. There is a need for staff to have adequate assessment skills in relation to pain management. This is an area for improvement in 1.3.3.3. The person centred care plans (PCCPs) in the 13 reviewed resident's file are reviewed every six months. The PCCP formats are consistent as sighted in 13 out of 13 reviewed resident's files. Post fall assessments are completed for all 13 incident reports sighted.

The witnessed hand overs are comprehensive to ensure the continuity of care with the use of a printed hand over sheets with the exemption of the tracer methodology three resident. The CM provides bureau RNs with a hand over sheet from the previous shift.

Tracer Methodology: Rest home level of care

The rest home unit resident undergoes regular medical procedure which results to nausea and vomiting. Food and fluid monitoring is completed by the staff as documented in the care plan. Foods are fortified and food supplements are provided for additional nutrition. The GP prescribes medications to reduce episodes of nausea and vomiting. The medications are effective as documented in the progress notes. Weights are monitored weekly to ensure that the resident's weight is not dropping secondary to frequent episodes of nausea and vomiting post medical procedure. A short term care plan is developed by the RN. The GP prescribed the appropriate antibiotics and the RNs evaluate the resident's response to the treatment. All interviewed staff are aware of the resident's condition and the planned interventions to manage weight loss. The relative is happy with the service provided by the service.

Tracer Methodology: Hospital level of care

The hospital unit resident had frequent falls since admission. The RNs complete a post fall assessment for every fall including vital signs as sighted in the documentation. The relative is consistently informed on each fall. The GP conducts regular medication reviews and there are documented assessment and plans by the physiotherapist. The physiotherapist's recommendations and daily reviews are evidence in the resident's file. A risk management plan to reduce falls is developed. The resident had three falls and was sent to the public hospital. The relative is aware of the resident's condition and commends the service for providing good care. All staff interviewed are knowledgeable about the resident's condition and interventions in place to minimise falls.

Tracer Methodology: Hospital level of care

Note: This is not required, however due to the two complaints by the families (one prior and one after hospitalisation) the managers find it prudent that the case be reviewed and an extra file is reviewed using tracer methodology because the resident's file has been reviewed by the coroner.

The hospital unit resident had a fall but this is not documented in the progress notes. There is no evidence that an incident report is completed. The resident is admitted to the public hospital and the service is advised to utilise full hoist for all transfers and to use a bed rail when the resident is in bed. The resident is also prescribed with analgesia to reduce pain secondary to an injury in the vertebrae. The RN completes a pain assessment and a short term care plan is developed. The restraint assessment is also completed and the restraint consent is signed. The caregivers complete the restraint monitoring as sighted in the evidence. The RN develops a new person centred care plan to address the resident's current condition. The restraint is only used for a month as reported by the CM. The resident's back pain is well managed by the staff by administering strong pain relievers (controlled drugs). The resident developed a chest infection and the RN developed a short term care plan with evidence of appropriate interventions. The GP prescribes antibiotics and response to treatment is documented. The resident had another fall and an incident report as well as post fall assessment are sighted. The fall is well documented in the progress notes. The resident is lifted back to the bed by two staff which is against the service's no-lifting policy. The resident started complaining of pain few hours after the fall and controlled drugs are administered. The effectiveness of the given analgesia is not clearly documented in the progress notes. The night RN noted some bruising early in the morning before the handover. The resident also remains complaining of pain and the RN administers more pain relievers to the resident. The RN notifies the family in the morning as evidence in the incident report. The CM reports that the RN handed over that the resident had a fall but no mention of a need for urgent hospitalisation or other special hand overs. The resident became more agitated in the morning and the CM verbalises that the resident screamed for hours after the morning handover. Another dose of analgesia is provided but the resident's pain remains uncontrolled. The physiotherapist conducts an assessment and provide recommendations including handling and transfers. The resident's agitation increased exponentially associated with confusion as reported by the staff which prompted the service to send the resident to public hospital for suspected infection. Three days later, the service is notified by the public hospital that the resident incurred multiple fractures. The resident stayed in the hospital for 15 days and returned to the service after five weeks of hospitalisation. The resident was discharged with a pain management pump and a week of antibiotics. The GP prescribed subcutaneous fluids and input/output is monitored as sighted in the evidence. The resident remains confused on return to the service as evidence in the progress notes. The CM reports that the resident is more settled a few days after being readmitted to the service. The resident is found unresponsive after few days of returning to the service and the GP confirms that stroke is the cause of death.

The District Health Board contract requirements are not fully 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:

Refer to 1.3.5.2

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:

The resident's needs, support requirements, and preferences are gathered and recorded in a timely manner. The RNs use a standardised assessment tools on admission to establish the required level of support of the resident and as the basis for RNs in developing the person centred care plans (PCCPs). This includes RN assessment, cognitive, mobility, dietary, nutrition/hydration, continence, oral, pressure risk, gait/balance, oral, pain, recreation, depression and cultural. The five out of five residents on regular analgesia or controlled drugs have pain assessments in file.

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: PA Moderate

Evidence:

The person centred care plans (PCCPs) in the 13 reviewed resident's files are resident-focused and have inputs from other members of the health team i.e. physiotherapist, mobility therapist and diversional therapist. The PCCPs are updated when the interventions are not effective as identified during regular assessments and reviews. The three out of 13 reviewed resident's files do not reflect issues around pain management although these residents are receiving regular controlled drugs. The short term care plans are not developed for all residents when the service had gastroenteritis outbreak. The CM reports that they followed the instructions by the infection control team on how to manage the outbreak. The PCCP of the tracer in the hospital unit does not contain the pain status of the resident. These are areas for improvement in 1.3.5.2.

The service has an integrated system in documentation. The RNs and caregivers document what happened during their shifts in one section while the GP and other members of the allied health team write in specific sections in the resident's file.

The District Health Board contract requirements are not fully met.

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

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

Attainment and Risk: PA Moderate

Evidence:

The desired outcomes/goals in the PCCPs are resident focused and realistic. The RNs develop these plans after undertaking the assessment process using standardised assessment tools.

Finding:

The PCCPs of the three reviewed resident's files do not reflect issues around pain management although these residents are receiving regular controlled drugs.

Short term care plans are not developed when residents are identified with gastroenteritis as part of the August 2014 outbreak.

The pain status of the resident is not reflected in the PCCP of the hospital unit resident for tracer methodology. Staff do not recognise that the resident's increase in agitation following the fall could be a sign of possible fracture that requires immediate intervention.

Corrective Action:

The PCCPs must reflect pain issues when residents are receiving regular controlled drugs.

Short term care plans must be developed for all acute infections.

All staff must have adequate assessment knowledge, skills and training in relation to pain assessment and pain management.

All PCCPs must reflect the pain status of the residents when present.

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The documented interventions in the 13 reviewed resident's file are sufficiently detailed to address the assessed needs and desired outcomes. Interventions in managing other infections are documented in the progress notes, short term care plans and PCCP's sighted with the exemption of the gastroenteritis outbreak in August 2014. Refer to 1.3.5.2. The gastroenteritis outbreak is resolved following the infection control-outbreak management policies and procedures.

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 activities provided by the diversional therapist (DT) are appropriate to the needs, age, culture, and setting of the service. These include physical, mental and social activities which the resident's prefer to participate. Activities are posted outside the occupational therapy lounge and in the dining areas. These activity plans are updated weekly by the diversional therapist. The weekly calendar of activities is provided to the residents every Friday in order for the residents to plan which activities they will attend.

The service provides church services as well as meditation sessions. The DT reports that the kauri unit residents are provided with activities that are similar to the rest home residents. Activities are provided that combines residents from the kauri, hospital and rest home units. The DT is supported by three diversional therapist assistants that cover the rest home, hospital and kauri units.

The interviewed residents verbalise that they enjoy the activities provided by the service.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All PCCPs in the 13 reviewed resident's files are evaluated every six month. The CM conducts a multi-disciplinary team review every six months. Interventions are resident focused and the response to treatment/intervention is documented. All short term care plans in the 13 reviewed resident's files have dates resolved documented. The RNs update the PCCPs and short term care plans when needed to address the desired outcome/goals. A frequent faller resident's PCCP reflects dated documentations of updates that show RN updating the PCCP with more appropriate interventions to address the desired outcome/goal.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.9: 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:

Residents are referred internally to other members of the allied health team like physiotherapist via a communication book. The physiotherapist visits daily for two hours per day and ensures that urgent matters are addressed immediately especially when residents had falls or changes in mobility status. The physiotherapist is supported by a mobility assistant who work five days per week. The outside referrals are facilitated by the CM. The CM refers residents to the speech language therapist and dietician when residents experience swallowing difficulties or choking episodes. A sample referral is sighted in the resident's file with swallowing issues.

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:

The service utilise a transfer document when residents are transferred to the public hospital or to another service. They also utilise the yellow envelope which is developed by the district health board when transferring resident to and from the public hospital. The resuscitation status, medication charts, latest progress notes, medical notes and current care plans are the documents included in the yellow envelope. Families are involved with the transfers/exits and discharges of the residents. The CM provides verbal hand overs when transferring the residents to another service.

The District Health Board contract requirement is 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:

The service has a medicine management system to ensure that the residents receive medicines in a safe and timely manner with the exemption of transcribing of medications. This is an area for improvement in 1.3.12.6. The medication charts are generated by the pharmacy and contain photos and allergies. The 24 out of 24 reviewed medication charts reflect three monthly reviews conducted by the GP. All discontinued medications are signed and dated by the GP.

The RNs in all four witnessed medication rounds are following the medication administration policies and procedures of the service. The RN uses the hand sanitiser in the medication trolley before and after administering medications. All staff who administers medications has current medication competencies as evidence in the file.

There no expired medications during the medication room inspection. Expired medications are returned to the pharmacy in a timely manner. The controlled drugs register is correct. All five out of five reviewed resident’s files who receive regular controlled drugs have a pain assessment completed in place. The impress stocks are used for the hospital unit and a good system is in place to monitor the use and replacement of the impress stocks.

The service crushes medications for three residents and the GP documents this in the three medication charts sighted. All RNs interviewed demonstrate good knowledge about side effects of crushing medications and the resident’s whose medications are crushed. One resident is on tube feeding thus requires crushing of medications.

There is one resident who self-administers medications. The RN completes a self-administration assessment tool as sighted in the resident's file. The GP reviews the self-medication assessment tool and the medication chart every three months. The self-administration policies and procedures are in place. The resident's blister packs are kept secured in a locked drawer in the room. Both the resident and the service have a key for the drawer. The CM reports that the resident receives adequate information about her medications. The resident confirms that the RNs provide information regarding the medications. The RNs checks the resident every shift to ensure resident's compliance and records this in the medicine administration signing sheets.

The medicine fridge is monitored daily as evidence by the monitoring sheets. There are sharp bins sighted in the medication room.

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: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The medication charts are generated by the pharmacy and the GP signs the medication charts on admission. There is evidence of three monthly reviews and all discontinued medications are signed and dated. All 24 out of 24 medication charts have photos and allergies. The GP documents on the medication chart when medications need to be crushed as sighted for three out of three medication charts.

Finding:

Out of 24 medication charts reviewed, there are five medications written in the non-packed medication signing sheets that show transcribing practices by the staff. This includes medications that are administered via injection or taken orally.

Corrective Action:

All staff administering medications must not transcribe medications.

Service to provide training for all staff in relation to medicine management, specifically on transcribing.

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents are provided with meals that meet their food, fluids and nutritional needs. The RNs complete the dietary requirement form on admission and provides a copy to the kitchen. Diet codes are sighted in the kitchen that prompts staff of the appropriate diet for the resident. This is updated by the RNs regularly. The service provides additional or modified foods depending on the need of the residents. This include puree, soft, mince/moist, high fibre and low sodium meals. The residents are provided with a daily menu checklist to inform the kitchen their preferred meals for the day. This is confirmed by the interviewed residents.

The kitchen staff monitors the two chillers three times in a day as evidence in the recording. The kitchen staff use clean technique in preparing meals for the residents. All prepared foods in the chillers like sandwiches are covered and dated. A kitchen cleaning schedule is sighted and completed daily. There is a food production and food service monitoring completed daily by the cook. Cooked meals are transported to the dining areas and in the rooms via covered plastic trolleys.

The service conducts monthly weighing of residents or more frequent as required as evidence in the weight monitoring folder. Weights are stable as sighted. The meals are well presented as sighted during the observed lunch. All staff serving meals are wearing gloves and disposable hats.

All 10 staff working in the kitchen have current food handling certificates. The kitchen manager is appointed to the current role six months ago. The kitchen manager places orders directly to the supplier. The kitchen manager reports that they use the first in-first out system for all their food supplies.

The summer menus are reviewed by the dietitian on September 2014 while the winter menus are reviewed on April 2014.

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:

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

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

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

Staff have last received training around infection control which includes waste management in June 2014. Household staff have all completed compulsory training in the circle of safety and clean care in 2014.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 16 March 2015). There have been no buildings modifications since the last audit however, there are room refurbishments and re-carpeting of the facility. There is a planned maintenance schedule implemented.

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

The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programmes two yearly and this is up to date having been completed in June 2014. BV Medical have checked all medical equipment in November 2013.

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

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

There are a number of checks of the facility including a six monthly ACC check, environmental audits annually and comprehensive fire equipment/sprinkler system checks by an external contractor. There is a schedule of monthly checks that are expected to be completed by the maintenance staff. These have been completed until December 2013.

An improvement is required to ensuring that the building checks are maintained as per schedule.

The District Health Board requirements are partially 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: PA Low

Evidence:

There are monthly checks by an external company around safety of the facility e.g. around the sprinkler system, fire exits and equipment.

There are six monthly ACC health and safety reports and action plans completed and there is an environmental audit completed as per schedule.

Finding:

The monthly maintenance checks have not routinely been completed in the first half of 2014 as per policy.

Corrective Action:

Ensure that monthly maintenance checks are completed as per policy.

Timeframe (days): 180 *(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:

There are adequate numbers of accessible toilets/bathing facilities. This includes full ensuite in some rooms, shared ensuite in some rooms and access to communal toilet facilities and shower facilities for all others. There visitors, toilets and communal toilets conveniently located close to communal areas.

Communal toilet facilities have a system that indicates if it is engaged or vacant and the last of these is being put in place following repainting of the areas. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

Residents and family interviewed including 12 residents (six rest home and six hospital) and 10 family members (four rest home and six hospital) interviewed report that there are sufficient toilets and showers.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

Equipment was sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff and the resident. Residents requiring use of a hoist were sighted on the day with staff supporting them in their rooms with sufficient space for all and three residents asked specifically if they were always supported by two staff when using a hoist confirmed that this occurred at all times.

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

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

There are three two-bedrooms remaining (note all other three and four bedrooms have been converted into single rooms) and all have curtains around each bed to allow for privacy as required. Two residents occupying a four bedroom are a couple and have the room to themselves.

The District Health Board requirements are met.

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

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

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:

The service has lounge/dining areas in each wing. All lounge areas are large with appropriate floor coverings. All areas are easily accessed by residents and staff.

There is a whanau room that is used for families and for residents requiring palliative care when family wish to be with their family member.

A large activity room was observed to be well used during the audit. Kauri wing is assisted living suites with a mix of residents requiring rest home or hospital level care. The activity room is at one end of the wing and the other end of the wing is near the reception area. There is a small resident day lounge with book shelves and television that residents can also use.

Residents are able to access areas for privacy if required.

Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.

The District Health Board 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:

Laundry is completed for three sites including Elmwood Village, Franklin and Takanini. There are three industrial washing machines and one small one for personal items and four industrial dryers. There is a large area in the laundry area to fold and return clothing with vans used to transport the linen to other sites. The laundry for each site is completed separately so that clothes and laundry does not get separated or lost.

There are cleaners on duty seven days a week and the cleaners are observed to have the trolley in the room with them when cleaning and all had appropriately labelled containers. Ecolab products are used with training around use of products last provided in 2014 (compulsory).

Cleaning is monitored through the internal audit process with no issues identified in audits completed in 2014.

Chemicals and cleaning cupboards are locked on the day of the audit.

The team leader facilitates monthly laundry meetings to identify and resolve any issues.

The seven health care assistants interviewed state that they make sure that when new residents and/or clothing come in, that all are named to avoid clothes being lost. They all state that this has reduced the number of missing items and there are no complaints in 2014 on the register around this.

The District Health Board 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 Low

Evidence:

An evacuation plan was approved by the New Zealand Fire Service in 31 January 2008. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place monthly with these being up to date in 2014. All staff are required to attend six monthly at least with records maintained. The orientation programme includes fire and security training. Staff confirm their awareness of emergency procedures.

There is always one staff member at least with a first aid certificate on duty – confirmed through review of the roster and confirmed by the business and care manager.

All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes by the external contractor. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ.

Back up emergency lighting is in place and this is fully checked and run for two hours annually. The system for emergency lighting has been replaced two months prior to the audit.

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

In the Kauri wing, staff on duty have access to other staff in the rest home and hospital in the event of an emergency with call bells connecting. At night there are two staff on duty in the Kauri wing and staff are required to sit in the corridors to monitor resident needs as the Kauri wing is ‘L’ shaped with a reception area at one end (unattended at night), a nurses station around the ‘L’ bend and another nurses station at the far end of the wing (staff located at all times in this station).

An electronic call bell system utilises a pager system in some areas and a display system in others. There are times in some areas where the call bell system becomes overloaded and not all calls are displayed. The service is currently replacing the whole system with contractors on site on the days of the audit. All staff are aware that at times the call bells are not displayed and there is a plan in place that is implemented that ensures that staff identify when residents use the bell system. This includes increased numbers of checks in place particularly when most residents are involved in activities. The staff interviewed including the health care assistants state that they remain aware of residents who require frequent checks or who require more checks because they are in the room when other residents are involved in communal activities. Call bell audits are routinely completed.

An improvement is required to complete the installation of the new call bell system.

The District Health Board requirements are partially met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

An electronic call bell system utilises a pager system in some areas and a display system in others. The service is currently replacing the whole system with contractors on site on the days of the audit. All staff are aware that at times the call bells are not displayed and there is a plan in place that is implemented that ensures that staff identify when residents use the bell system. This includes increased numbers of checks in place particularly when most residents are involved in activities.

Finding:

There are times in some areas where the call bell system becomes overloaded and not all calls are displayed.

Corrective Action:

Complete the installation of the new call bell system.

Timeframe (days): 180 *(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. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.

Family and residents interviewed confirm the facilities are maintained at an appropriate temperature. There is a 600-kilowatt gas-fuelled boiler used for domestic and heating that is checked six monthly – last checked in June 2014.

The District Health Board 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 demonstrates that the use of restraint is actively minimised. There are currently three hospital residents on restraints and they are using bedrails while on bed. There is no resident using an enabler. An updated restraint register is sighted. Assessment and consent forms are sighted in the three resident's files on restraint. Risk minimisation is documented in the all three residents' PCCPs-restraint section. Restraints are evaluated every three months as sighted in the evidence. The resident and families are also provided enough information regarding the restraint used.

All staff has current restraint competency as sighted.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

The restraint coordinator reports that the restraint approval committee include the restraint coordinator, rest home clinical manager, two caregivers and the mobility therapist. The type of restraint appropriate for the residents, duration of the restraint, risk managements plans, and in-service trainings are determined by the restraint approval committee. The restraint minimisation and safe practice policy and procedure is in place.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The restraint coordinator completes a restraint assessment form prior commencing any resident on restraint. This is evidence in the three out of three reviewed resident's files on bedrails in the hospital unit. The risk factors are identified in the assessment as well as the resident's current condition why the restraint is necessary. The desired outcome is clearly documented and reported to the resident/family. Other possible strategies are also documented.

The District Health Board contract requirement is 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 provider use restraint safely. There are currently three residents on restraint. The restraint register is current and the PCCPs-restraint section have documented risk management plans. All interviewed RNs and caregivers demonstrate excellent knowledge about restraints, enablers and are able to discuss risk management plans to prevent injury on the resident. The restraint minimisation policies and procedures are in place and accessible for all staff to read. The restraint coordinator verbalise that there no restraint-related injuries reported.

The District Health Board contract requirement is met.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The restraint coordinator evaluates all three restraints currently in use as evidence in the documentation. The GP and the resident's family sign the three monthly evaluation forms. This also includes evaluating the effectiveness of the restraint in use and the risk management plans documented in the PCCPs-restraint section.

The District Health Board contract requirement is 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:

The service demonstrate monitoring and quality review of the use of restraint. The restraint committee is compose of the restraint coordinator, hospital clinical manager, two caregivers and mobility therapist. Restraint committee meetings are conducted every two months, the last meeting is conducted on July 2014. The restraint minutes are reported to the head office for quality monitoring purposes.

The restraint minimisation policies and procedures are reviewed annually as sighted.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The RN and an enrolled nurse (EN) share the infection control co-ordinator role and the job description is signed off as evidence in the file.

The facility has a clearly defined infection control program that is reviewed annually, sighted. Infection control is part of health and safety meeting every month. The use of antibiotics is monitored and recorded infection log which includes the date the infection is identified, type, prescribed antibiotics, length prescribed and the date the infection is resolved. The infections rates are entered into the organisation's intranet system for benchmarking purposes as verified.

The RN commences a short term care plan and is signed off when the infection is resolved. It is also reflected in the progress notes.

Infectious diseases prevention policy is in place to prevent visitors suffering from, or exposed to and susceptible to, from exposing others while still infectious. Resident's families and relatives are encouraged not to visit when they are unwell. Hand sanitizers are in the main reception area as well as in the corridor of the rest home, hospital and kauri units.

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.)*

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:

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. The RN and an enrolled nurse (EN) share responsibility in leading the infection control committee. The infection control committee has representatives from different areas in the service like caregiving, laundry, maintenance and cleaning. Hand washing signs are sighted around the facility to remind staff and the residents the importance of having proper hand washing. The organisation maintains a regular in-service training for infection control including standard precautions, personal protective equipment's, laundry care and hand washing.

The infection control coordinators access information via the organisation's intranet system.

The service had an outbreak and this is managed well by the service. Staff are provided with more information on outbreak management and infection control. Visitors are not allowed to visit their relatives during the outbreak until informed by the service. The outbreak was resolved prior to the audit.

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:

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. The infection control policies and procedures are sighted. The service evidences implementation of the policies and procedures.

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:

The organisation provides relevant education on infection control to all service providers, support staff, and residents. The infection control education is provided by either the infection control coordinators (ICC) or by other invited resource speakers. All staff complete an annual infection control quiz as part of the annual update. All staff have hand washing competencies as sighted. Infection control training record is sighted. Staff are able to discuss the importance of proper hand washing and how to break the chain of infection. Staff in the kitchen wear gloves when preparing meals. Caregivers wear gloves when taking care of the residents and remove the gloves after providing cares.

Residents interviewed are also aware of the importance of hand washing and mentioned when hand washing is required. The ICC also reports that the importance of handwashing as evidence in the resident's meeting minutes.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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.)*