Oceania Care Company Limited - Everill Orr Village

Current Status: 6 October 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

Everill Orr, (part of the Oceania Group) can provide care for up to 106 residents. During the audit there were 93 residents living at the facility including 43 residents requiring rest home level care and 50 residents requiring hospital level care. The business and care manager was responsible for the overall management of the facility with the clinical manager who provided clinical oversight.

Service delivery was monitored through complaints, health and safety, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys.

The staffing policy was the foundation for workforce planning. Staffing levels were reviewed for anticipated workloads and acuity with rosters documented.

Improvements are required to performance review, activities programme, review of the registered nurse in the rest home and ventilation in the laundry rooms.

Audit Summary as at 6 October 2014

Standards have been assessed and summarised below:

Key

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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 6 October 2014

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

Organisational Management as at 6 October 2014

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

Continuum of Service Delivery as at 6 October 2014

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

Safe and Appropriate Environment as at 6 October 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 6 October 2014

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

Infection Prevention and Control as at 6 October 2014

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

Audit Results as at 6 October 2014

Consumer Rights

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. The residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence.

Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family. The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent policy and processes are implemented by the service. The staff ensure residents are informed and have choices related to the care they receive. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

Organisational Management

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

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation/induction programme that provides new staff with relevant information for safe work practice and an ongoing training programme.

There is a policy for determining staffing and skill mix for safe service delivery. Staff identify that staffing levels are as per policy and interviews with residents and relatives demonstrate that they have adequate access to staff to support residents when needed. There is a business and care manager and clinical manager who both have experience in aged care.

An improvement is required to the performance appraisal for the business and care manager.

Continuum of Service Delivery

The residents` records provide evidence that all residents have been assessed appropriately prior to admission to the facility by the needs assessment service co-ordinators. The provider has well

implemented systems to assess, plan and evaluate the care needs of the residents. The resident`s needs, desired outcomes/goals have been identified and these are reviewed on a regular basis with family input. A team approach to care delivery and continuity of care is encouraged. There is an area of requiring improvement in relation to the hospital level residents` care in the rest home.

Medication management is safely implemented. A visual inspection of the medicine systems and the lunchtime medication round in the rest home and the hospital evidences compliance with respective legislative requirements, regulations and guidelines. The general practitioners review medications three monthly or more often if required. The contracted pharmacist completes audits six monthly and reconciliation of medications occurs for every newly admitted resident and or residents discharged to the facility from the DHB.

The activities programme is provided and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are arranged to be meaningful and the programme is developed and implemented to ensure the interests of residents are included. There is one area of requiring improvement in relation to the activities planned for the younger persons disabled. Outings are arranged in the community when possible and groups and individual entertainers are welcome to visit and to participate in the programme.

The catering service policies and procedures are appropriate for this service setting. The service is managed by the kitchen team leader. The menu plans have been reviewed by the Oceania Group dietitian and are suitable for the elderly and/or disabled residents. The menus are displayed daily. The individual dietary needs identified during the assessment process for each resident on admission is addressed and choices are provided. Meals and fresh baking is provided at appropriate times of the day. The service won an award for 2013 `Excellence in food for care homes and hospital` and this is clearly displayed in the entrance.

Safe and Appropriate Environment

All building and plant comply with legislation. There is a maintenance person and planned and preventative maintenance programme including equipment and electrical checks.

Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Activities can occur in any of the lounges and furniture is arranged to ensure residents are able to move freely and safely. Personal laundry is completed on site and the managers monitor the site to ensure that it is kept clean and safe.

Essential emergency and security systems are in place with regular fire drills completed. Emergencies and first aid are included in the training programme. There is a civil defence kit for the whole facility. Call bells are evident across the facility in resident’s rooms, lounge areas, and toilets/bathrooms and all are monitored to ensure that they are functioning at all times.

An improvement is required to one laundry room to ensure there is ventilation.

Restraint Minimisation and Safe Practice

The service has developed and implemented policies and procedures for restraint minimisation and safe practice should restraint or an enabler be used. There is only one enabler in use. There is a clear definition of an enabler to guide staff. Clinical staff complete restraint education as part of the orientation programme and education is ongoing. Restraint competencies are completed

annually by all staff and records are maintained. The documentation meets the requirements of the health and disability services restraint minimisation standard.

Infection Prevention and Control

Everill Orr has an infection prevention and control system in place. Policies and procedures are relevant for the size and nature of this aged care setting. There is an infection control co-ordinator who is an experienced registered nurse who when interviewed is fully informed of responsibilities and the obligations of this role. Infection control is an integrated part of the quality and risk system and staff receive feedback at their monthly meetings.

Infection control prevention and control is benchmarked with other facilities in the wider organisation and this is promoted. There is an in-service education programme and there is evidence of staff receiving relevant education and all staff have completed hand hygiene competencies annually.

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 - Everill Orr Village

Designated Auditing Agency:	Health Audit (NZ) Limited

Types of audit:	Certification Audit
Premises audited:	Everill Orr Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	**Start date:** 6 October 2014 **End date:** 7 October 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:	93

Audit Team

Lead Auditor	Tricia Doré	**Hours on site**	16	**Hours off site**	8
Other Auditors	Christine Davies	**Total hours on site**	16	**Total hours off site**	6
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	Zdena Kaspar-West			**Hours**	3

Sample Totals

Total audit hours on site	32	Total audit hours off site	17	Total audit hours	49

Number of residents interviewed	13	Number of staff interviewed	12	Number of managers interviewed	3
Number of residents' records reviewed	10	Number of staff records reviewed	10	Total number of managers (headcount)	3
Number of medication records reviewed	20	Total number of staff (headcount)	82	Number of relatives interviewed	6
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, 20 October 2014

Executive Summary of Audit

General Overview

Everil Orr, (part of the Oceania Group) can provide care for up to 106 residents. During the audit there were 93 residents living at the facility including 43 residents requiring the rest home level of care and 50 residents requiring hospital level of care. Seven residents were identified as being under 65 years of age. The business and care manager was responsible for the overall management of the facility with the clinical manager who provided clinical oversight.

Service delivery was monitored through complaints, health and safety, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys.

The staffing policy was the foundation for workforce planning. Staffing levels were reviewed for anticipated workloads and acuity with rosters documented.

Improvements are required to performance review, activities programme, review of the registered nurse in the rest home and ventilation in the laundry rooms.

Outcome 1.1: Consumer Rights

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. The residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence.

Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family. The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent policy and processes are implemented by the service. The staff ensure residents are informed and have choices related to the care they receive. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

Outcome 1.2: Organisational Management

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

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation/induction programme that provides new staff with relevant information for safe work practice and an ongoing training programme.

There is a policy for determining staffing and skill mix for safe service delivery. Staff identify that staffing levels are as per policy and interviews with residents and relatives demonstrate that they have adequate access to staff to support residents when needed. There is a business and care manager and clinical manager who both have experience in aged care.

An improvement is required to the performance appraisal for the business and care manager.

Outcome 1.3: Continuum of Service Delivery

The residents` records provide evidence that all residents have been assessed appropriately prior to admission to the facility by the needs assessment service co-ordinators. The provider has well implemented systems to assess, plan and evaluate the care needs of the residents. The resident`s needs, desired outcomes/goals have been identified and these are reviewed on a regular basis with family input. A team approach to care delivery and continuity of care is encouraged. There is an area of requiring improvement in relation to the hospital level residents` care in the rest home.

Medication management is safely implemented. A visual inspection of the medicine systems and the lunchtime medication round in the rest home and the hospital evidences compliance with respective legislative requirements, regulations and guidelines. The general practitioners review medications three monthly or more often if required. The contracted pharmacist completes audits six monthly and reconciliation of medications occurs for every newly admitted resident and or residents discharged to the facility from the DHB.

The activities programme is provided and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are arranged to be meaningful and the programme is developed and implemented to ensure the interests of residents are included. There is one area of requiring improvement in relation to the activities planned for the younger persons disabled. Outings are arranged in the community when possible and groups and individual entertainers are welcome to visit and to participate in the programme.

The catering service policies and procedures are appropriate for this service setting. The service is managed by the kitchen team leader. The menu plans have been reviewed by the Oceania Group dietitian and are suitable for the elderly and/or disabled residents. The menus are displayed daily. The individual dietary needs identified during the assessment process for each resident on admission is addressed and choices are provided. Meals and fresh baking is provided at appropriate times of the day. The service won an award for 2013 `Excellence in food for care homes and hospital` and this is clearly displayed in the entrance.

Outcome 1.4: Safe and Appropriate Environment

All building and plant comply with legislation. There is a maintenance person and planned and preventative maintenance programme including equipment and electrical checks.

Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Activities can occur in any of the lounges and furniture is arranged to ensure residents are able to move freely and safely.

Personal laundry is completed on site and the managers monitor the site to ensure that it is kept clean and safe.

Essential emergency and security systems are in place with regular fire drills completed. Emergencies, and first aid are included in the training programme. There is a civil defence kit for the whole facility. Call bells are evident across the facility in resident's rooms, lounge areas, and toilets/bathrooms and all are monitored to ensure that they are functioning at all times.

An improvement is required to one laundry room to ensure there is ventilation.

Outcome 2: Restraint Minimisation and Safe Practice

The service has developed and implemented policies and procedures for restraint minimisation and safe practice should restraint or an enabler be used. There is only one enabler in use. There is a clear definition of an enabler to guide staff. Clinical staff complete restraint education as part of the orientation programme and education is ongoing. Restraint competencies are completed annually by all staff and records are maintained. The documentation meets the requirements of the health and disability services restraint minimisation standard.

Outcome 3: Infection Prevention and Control

Everil Orr has an infection prevention and control system in place. Policies and procedures are relevant for the size and nature of this aged care setting. There is an infection control co-ordinator who is an experienced registered nurse who when interviewed is fully informed of responsibilities and the obligations of this role. Infection control is an integrated part of the quality and risk system and staff receive feedback at their monthly meetings.

Infection control prevention and control is benchmarked with other facilities in the wider organisation and this is promoted. There is an in-service education programme and there is evidence of staff receiving relevant education and all staff have completed hand hygiene competencies annually.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	41	0	3	1	0	0
Criteria	0	89	0	3	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	5
Criteria	0	0	0	0	0	0	0	8

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide	PA Low	The business and care manager does not have a current performance appraisal (last	Ensure that there is an annual performance appraisal for the business and care	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		safe and effective services to consumers.		completed in March 2013).	manager as per policy.	
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	Criterion 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.	PA Moderate	The design of the rest home is on two levels and includes several different wings. The number of staff allocated to cover the rest home needs to be revised as these factors are compromising continuity of care in particular for the seven hospital level residents. The registered nurse was not seen to be available in the rest home at all times should an emergency situation arise.	To ensure the hospital level residents are allocated appropriately in the rest home for prompt care and service delivery and that staffing is maintained at all times to ensure registered nurse cover is available at all times for all residents in the event of an emergency.	60
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low			
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and	PA Low	Activities are documented as being	To ensure the programme is	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.		provided in both the hospital and the rest home. However, the activities provided for the younger disabled persons is difficult to validate for the seven residents receiving services.	developed and implemented to meet the needs of all residents.	
HDS(C)S.2008	Standard 1.4.6: Cleaning And Laundry Services	Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Low			
HDS(C)S.2008	Criterion 1.4.6.3	Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Low	One laundry room in the rest home building does not have external ventilation.	Ensure that all laundry rooms are ventilated.	90

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:

Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. Interviews with the clinical manager, six of six health care assistants and two 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 and complaints was last provided in March and September 2014.

The auditors noted respectful attitudes towards residents on the days of the audit.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

A registered nurse discusses the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code are also held at the monthly residents' meetings (meeting minutes sighted). Residents and family interviews 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 both in the hospital building and in the rest home. The Code of rights posters are on the walls in the service.

Resident right to access advocacy services is identified for residents and advocacy service leaflets are available at the entrance to the service. 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.

Thirteen residents (seven rest home and six hospital) and six family members (three hospital and three rest home) interviewed are able to describe their rights and advocacy services particularly in relation to the complaints process.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The 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 assessments include gaining details of people's beliefs and values with the registered nurses and clinical manager interviewed stating that the care plans are completed with the resident and family member (confirmed by residents and family interviewed). Interventions to support these are identified and evaluated. Residents are addressed by their preferred name and this is documented in 10 of 10 files reviewed.

A policy is available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality (sexuality and intimacy) in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour. Staff have received training around sexuality and intimacy last in July 2014.

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.

Six health care assistants interviewed report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirm the residents' privacy is respected.

Health care assistants interviewed report that they encourage the residents' independence by encouraging them to be as active as possible. A physiotherapist assistant is available four days a week in the morning with the physiotherapist available two to three hours a week to oversee programmes. Health care assistants assist residents with their activity programmes.

The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. They are committed to provide guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the organisation's mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code.

Staff receive mandatory education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation. Staff interviewed are aware of the signs of abuse and neglect with training provided April 2014.

Resident files reviewed (10 of 10) identify that cultural and /or spiritual values, individual preferences are identified and these are discussed as part of the monthly meetings as issues are identified as described by the clinical manager and business and care manager. There are weekly church services and a fortnightly bible study group. There is a chapel on site.

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)
Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)
Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)
Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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

Attainment and Risk: FA

Evidence:

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 and include the Auckland University of Technology.

There are two Maori residents living at the facility and one staff member who identifies as Maori.

Staff interviewed report specific cultural needs are identified in the residents' care plans. This was further evidenced in 10 of 10 resident files selected for review (five hospital and five rest home). Staff are aware of the importance of whanau in the delivery of care for their Maori residents.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The 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 remains a person, even in a state of physical or mental decline.

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 13 residents and six family members interviewed).

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

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 10 of 10 staff files reviewed.
The orientation and employee agreement provided to staff on induction includes standards of conduct.

Interviews with staff including the diversional therapist, six health care assistants across hospital and rest home, two registered nurses and the clinical manager confirm their understanding of professional boundaries, including the boundaries of the health care assistants' role and responsibilities.

Staff describe supporting residents identified as being young people with a disability with promotion of independence and integration into the community as much as possible (refer 1.3.7.1).

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:

Everil Orr implements Oceania policies to guide practice. These policies align with the health and disability services standards and are reviewed two yearly. There is a quality framework that supports an internal audit programme. Benchmarking occurs across all the Oceania facilities.

There is a training programme and managers are encouraged to complete management training. Specialised training and related competencies are in place for the registered nursing staff. There is a monthly regional management meeting.

Residents and families interviewed express a high level of satisfaction with the care delivered overall with two residents and one family member stating that there are only concerns with answering the call bells in a timely manner (Refer 1.3.3.1).

The general practitioner reports a high standard of care is provided at the service and the registered nurses demonstrate good clinical assessment skills.

Consultation is available through the organisation's management team that includes registered nurse, dietician etc. A physiotherapist is available for two to three hours a week.

Key projects that are currently in progress include the following in 2013: i) management of skin tears with evidence that includes a reduction in wound infection rates, ii) increase in hairdressing hours, iii) falls and urinary tract infections, iv) review of the dining experience, v) redesign of the reception are; and in 2014 - vi) resident connection with the community, vii) redevelopment of the garden at the front of the service.

The business and care manager, clinical manager and the clinical and quality manager are committed to improving service delivery at Everil Orr.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; 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 10 of 10 files reviewed.

Interviews with six family members (three hospital and three rest home) confirm they are kept informed. Family also confirm that they are invited at least annually to the care planning meetings for their family member. Family interviewed confirm that they are invited to attend the monthly resident meetings.

Staff state that there are no residents requiring the use of an interpreter although interpreters are available if required. There are residents who have English as a second language. There are staff on site who can speak with the resident on all shifts. Residents with English as a second language include Pacific Island residents and Indian. One Indian family member states that there are always staff on duty who can converse with the resident and family come in at least daily to be with their family member. A resident interviewed with English as a second language states that they is very well supported and cultural needs are addressed. The family member also interviewed states that staff are supportive and talk in the resident's language.

The information pack is available in large print and advised that this can be read to residents. Staff have had training around communication in May and September 2014. Staff have had training around the complaints process and open disclosure last in September 2014.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: 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, outings and photos. There is a consent for non-routine treatment or procedure completed e.g. for the flu injection.

There are advance directives used with residents who are competent to have a resuscitation order signing the form. Ten of ten admission agreements sighted have all been signed on the day of admission.

Discussion with residents and family identify that the service actively involves them in decisions that affect their lives.

The District Health Board contract 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.

The diversional therapist is responsible for facilitating the three monthly resident meetings with the business and care manager attending (note that a meeting is held for residents in the hospital building and a meeting held for residents in the rest home building). Staff training on the role of advocacy services is included in training on Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) training – last provided for staff in September 2104.

Discussion with family and residents identify that the service provides opportunities for the family/EPOA (enduring power of attorney) to be involved in decisions and they state that they have been informed about advocacy services.

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

Staff including the six 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 contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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. Families interviewed confirm they can visit at any reasonable time and are always made to feel welcome.

Family are seen coming and going freely on the days of the audit although staff state that on the days of the audit due to weather conditions, there were less visitors than normally expected.

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 and going to activities such as shopping and going out to cafés.

Residents have performing groups who entertain residents as observed on the day of the audit. Residents are included in outings with families.

The District Health Board contract requirements are met.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The organisation's complaints policy and procedures is in line with the Code and includes time frames for responding to a complaint. Complaint 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 folder.

Two complaints lodged in 2014 are selected for review. There is documented evidence of time-frames being met for responding to these complaints.

Thirteen residents (seven rest home and six hospital) and six family members (three hospital and three rest home) all state that they would feel comfortable complaining.

The business and care manager states that there have been no complaints with the Health and Disability Commission since the last audit and the complaint lodged with the District Health Board in December 2013 is now closed out as confirmed through completion of the corrective actions required at the last surveillance audit.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Everil Orr is part of the Oceania group with the executive management team including the chief executive officer, general manager, operations manager, regional operational manager and clinical and quality manager providing support to the service.

Communication between the service and managers takes place on a monthly basis with the current clinical and quality manager providing support for the service on the days of the audit.

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'.

The facility can provide care for up to 106 residents (41 rest home beds and 65 hospital beds). The hospital residents are located in one building on the site and there is a capacity of 17 dual purpose beds in the rest home building with seven residents requiring hospital level care in the rest home building. During the audit there are 93 residents living at the facility including 43 residents at the rest home level of care and 50 residents at hospital level of care. Seven residents are under 65 years of age including two in the hospital and five requiring rest home level care.

The business and care manager is responsible for the overall management of the facility and has been in the role for three and a half years. The business and care manager is a registered nurse (with current annual practicing certificate) who has had over seven years' experience in aged care. Professional development relating to the management of an aged care facility exceeds eight hours for each year in the service with certificates reviewed confirming this.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)
The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)
The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

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

Attainment and Risk: FA

Evidence:

In the absence of the business and care manager, a clinical manager is in charge with support from the clinical and quality manager. The current clinical manager has been employed at the service for the past seven years.

The clinical and quality manager provides support to a number of Oceania facilities. The clinical and quality manager is a registered nurse, has a certificate in business management, diploma in management and over 13 years' experience in aged care including home care and hospital/rest home/dementia facilities.

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:

Everil Orr 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.

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 five of the six health care assistants specifically asked.

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. Corrective action plans evidence that issues are addressed with date of resolution documented. There is documented evidence of communication with staff in the health and safety, infection control, quality and staff meetings as well as in the registered nurse and restraint meetings. All staff interviewed (six health care assistants, two registered nurses, the clinical manager, the diversional therapist, one cook) report they are kept informed of quality improvements and corrective action plans. Results are benchmarked across all Oceania aged care facilities with a business status report completed by the business and care manager monthly (sighted). This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products.

There is an annual family and resident satisfaction survey which took place in November 2013. The overall level of satisfaction rate of residents and families is satisfactory to very satisfactory.

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 for each part of the service e.g. kitchen, office, care provision room. There is evidence of hazards identification forms completed when a hazard is identified and the hazard form updated. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.

The organisation holds a current ACC Work Safety and Management Practice tertiary level accreditation. Health and safety is audited monthly.

There are monthly meetings around review of data and discussion around quality and risk that include the following: quality and risk, operational, health and safety, household, full staff meetings (referred to as multi-disciplinary meetings), registered nurse, restraint, health care assistant and infection control. Meeting minutes are documented – reviewed for 2014.

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 are no times since the last audit when authorities have had to be notified. There have been no outbreaks since the last audit.

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

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

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

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

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

Ten staff files randomly selected for review include evidence of recruitment documentation 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 apart from the business and care manager who's last appraisal was completed in 2013. An improvement is required to ensure that the business and care manager has a current performance appraisal. First aid certificates are held in the staff files. Police checks are completed.

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract.

Health care assistants are paired with a senior caregiver 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 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.
The organisation has a mandatory education and training programme with sessions held monthly. Staff attendances are documented and there is evidence of staff attendance with other staff who do not attend required to review training material. The six 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 partially 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: PA Low

Evidence:

There is an annual appraisal process in place with all staff having a current performance appraisal apart from the business and care manager who's last appraisal was completed in 2013.

Finding:

The business and care manager does not have a current performance appraisal (last completed in March 2013).

Corrective Action:

Ensure that there is an annual performance appraisal for the business and care manager as per policy.

Timeframe (days): 180 *(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.

The service operates from two buildings. One is designated as being for hospital residents and one for rest home residents with 17 beds identified as dual purpose beds in the rest home building (all upstairs).

The rosters for an occupancy for residents in the hospital building (50 residents) is as follows: two registered nurses in the morning and afternoon with one overnight; seven health care assistants in the morning and afternoon (three upstairs, three downstairs and one in a wing known as Tyler) and three health care assistants overnight.

The rosters for an occupancy for residents in the rest home building (43 residents requiring rest home level care and seven requiring hospital level care) is as follows: one registered nurse at all times noting that the registered nurse does leave the building with a walk to the hospital building to complete tasks as needed (Refer 1.3.6.1); six health care assistants in the morning (including four upstairs and two downstairs), five in the afternoon (including three upstairs and two downstairs) and three overnight (one downstairs and two upstairs).

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

Residents and families interviewed confirm staffing is adequate to meet the residents' needs in the hospital area and downstairs in the rest home however one family member and two residents in the main rest home area upstairs state that at times their call bell takes a long time to be answered (Refer 1.3.3.1).

There are currently 82 staff including the business and care manager, clinical manager, 10 registered nurses, a diversional therapist , maintenance, diversional therapist (refer 1.3.7.1), cleaners and cooks seven days a week and 53 healthcare assistants.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

Residents' 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 policy identifies entry processes which are communicated to residents, family/whanau and referral agencies. The processes are documented to guide staff. The administrator and the business and care manager are responsible for the enquiries, potential resident details, care type/level, general comments and a check list of referral information. Information is available on the Oceania website about this facility and the services offered. The first point of contact is generally with the administrator. Tours of the facility can be arranged. If a tour is required out of business hours one of the registered nurses is able to perform this function. The administrator informs the family if and when required.

Ten resident records (five rest home and five hospital) sighted have the initial assessment which is completed for each resident on admission. The administrator ensures the needs assessment and service co-ordinations assessors (WDHB) or (ADHB) information (NASC) is filed in a separate folder with the residential care service agreements. Five individual folders were provided for review. These documents are retained and filed in a locked cabinet in the main office. The NASC assessment reports are comprehensive with all support needs being identified and summarised with options for meeting the needs and goals established, plus the outcome of the nursing assessment documented.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The policy describes processes undertaken should entry to the service be declined. This includes notification to appropriate persons and agencies. The resident has to have the appropriate level of care ascertained prior to admission to the rest home or hospital services provided at this aged care residential service site.

The two registered nurses at interview report that entry is not declined where a resident has an appropriate assessment and there is a bed available. There is a statement in the residential care agreement that indicates when a resident is required to leave the service. If a resident requires a higher level of care such as secure dementia environment a referral is sent by the contracted general practitioner or the clinical manager for an assessment to be completed by the NASC service. The resident register is kept up to date at all times and if any changes occur they are recorded accurately.

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 person centred care plans are reviewed six monthly or more often if required. The registered nurses (RN) review the care plans and information is updated following the multidisciplinary reviews also organised by the registered nurses. The schedule is available and discussed with the clinical manager. The RNs are allocated a number of residents to be responsible for at this service. The reviews are dated and signed off and there is evidence of resident/family input into the reviews sighted. There is a process for checking the annual practising certificates (APCs) for all health professionals involved with this service. All APCs are available and sighted. The registered nurses have all completed the required educational hours and records of education are readily available. There are 10 registered nurses and the service is awaiting one new graduate registered nurse which will bring the total RNs to 11. Two registered nurses and six health care assistants at interview enjoy working in the rest home and the hospital and verify educational opportunities are encouraged.

There are seven hospital level residents in the rest home. The rest home is a separate building from the main hospital. A registered nurse is available twenty four hours a day, seven days a week. On the tour of the facility a resident was found to be in their allocated room at the end of a wing some distance from the staff nurses station. The resident was obviously compromised, upset and not well enough to summon assistance of the nursing staff. No staff was readily available at the time. This is an area identified as requiring improvement.

The District Health Board contract requirements are partially met.

Tracer Methodology: Rest Home

The resident has been in the rest home for approximately two years. The resident has mental health and other medical concerns. Short term care plans have been instigated five times in the last three months for a chest infection, weight loss, poor hearing and itchy skin. The resident displays regular psychotic symptoms with six episodes of challenging behaviour being observed in the last two months. The staff have to complete accurately a `behaviour that challenges monitoring form` and record each episode. After one incident recorded in 2013, the resident had four falls and threats of violence are noted in the progress records, no significant incidents have been reported.

There is a detailed management plan reviewed which provides a plan for staff to de-escalate a situation should it arise and restore equilibrium for the benefit of the resident and other residents. On the plan suitable interventions suggested are marked by the registered nurse as to which are appropriate for the resident for example talk calmly, remove others or use PRN (as necessary) medication. Details of diversional activities to be used for behaviour management over 24 hours are suggested as well and resources are available for staff to access. Additional assessments during the review were undertaken such as mobility assessment, Tinetti risk assessment, Waterlow pressure area, continence assessment and cultural assessment. The resident states they does not find the activities suitable or that meet their needs. Enjoys the food and is cared for appropriately.

Evaluations of the interventions are signed off and dated by the registered nurse reviewing the management plan in place. The resident has 12 goals documented in the person centred care plan. The multidisciplinary review (MDR) last performed evidences input from the pharmacist, GP, diversional therapist, dietitian, key caregiver, physiotherapist and family being clearly documented. The MDR is signed off by family/resident and the registered nurse.

Tracer Methodology: Hospital

This resident has been in the facility for about 18 months. A family member has full enduring power of attorney as the resident is not deemed competent to a make an advanced directive. The form is signed off by the general practitioner (GP). Communication on a regular basis is recorded on the communication with family/friend/representative sheet. Communication is made directly with the use of body language by the staff. The staff at interview report they encourage simple language, simple questions for example head nodding, thumbs up and waving hands to effectively communicate with the resident. This is documented in the person centred care plan.

The resident`s medication records evidence regular reviews by the resident`s GP and the pharmacist. Mobility is an issue requiring the use of hoists transfer and slide and two health care assistants when transferring. Interventions are clearly documented to maintain skin integrity and to decrease the risk of skin infections. The resident is incontinent and a complaint received from family after the multidisciplinary review recently was investigated and actioned by the business and care manager in relation to continence management. A positive outcome was sought and received from family. Family interviewed are pleased with the comprehensive care provided to the resident and visit daily.

Nutrition is maintained by continuous peg tube feeding with the rate and quantity each day being documented on the feeding chart Staff follow protocol for positioning and caring for the equipment and administration of medication via the peg tube. The resident`s weight is closely monitored and a goal to maintain an effective BMI is acknowledged and managed effectively. Dietitian input is promoted. Staff report any changes are reported to the registered nurse and the clinical manager.

Tracer Methodology: Younger person disabled.

The resident is one of seven (two hospital and five rest home) under 65 year olds at this rest home. The pre-admission information reviewed is appropriate and the resident has been in the rest home for some time now. The current GP has cared for this resident for approximately 24 years prior to entry to this service and since admission. The resident likes to be visited by the GP three monthly or more often if required. At interview the resident reports they are happy at this rest home and like the meals and join in the activities they like to participate in. Generally the resident maintains a stable health status except for a recent urinary tract infection which was treated with antibiotics. A short term person centred care plan is developed and implemented and signed off when the issue resolved and the antibiotic course was completed. The date of antibiotics stopping is not recorded on the medication record.

The last multidisciplinary review is documented as May 2014 and this evidences input from the GP, registered nurse, family, health care assistants and the pharmacist. The resident is fully supported by a family member who was not available to be interviewed.

Referral letters are evident in the individual resident`s record for haematology clinic and the DHB dental unit. A dental extraction was required ensuring his oral health has been reviewed as part of the person centred care plan implemented.

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: PA Moderate

Evidence:

There are seven hospital level residents in the rest home, a separate building on the same site as the main hospital. It was noted that the registered nurse was completing tasks in the main hospital on several occasions during the audit.

Finding:

The design of the rest home is on two levels and includes several different wings. The number of staff allocated to cover the rest home needs to be revised as these factors are compromising continuity of care in particular for the seven hospital level residents. The registered nurse was not seen to be available in the rest home at all times should an emergency situation arise.

Corrective Action:

To ensure the hospital level residents are allocated appropriately in the rest home for prompt care and service delivery and that staffing is maintained at all times to ensure registered nurse cover is available at all times for all residents in the event of an emergency.

Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The 10 residents` records (five rest home and five hospital) reviewed include continence assessments and management procedure, wound care management procedures, wound care protocols and behaviour management processes, which include seeking expert advice and assistance such as mental health services, as required. The assessments are sighted for challenging behaviour, dietary requirements, falls, neurological observations, pain, skin management and other assessment tools. The assessments are done six monthly when the care plans are reviewed by the registered nurses, as per the schedule developed and implemented or when a need is clearly identified. The clinical manager explains this process for the person centred care plans to be reviewed. There are 10 registered nurses who share this review process responsibility. Each registered nurse also organises the multidisciplinary review for their respective residents.

The two registered nurses interviewed report interventions if implemented are recorded on the person centred care plans. If risk of falls is classified as high risk additional assessments for balance and gait may be required by the physiotherapist who is contracted to this service.

The NASC assessment which is a full interRAI assessment is used to serve as the basis of service delivery care planning. Also the residents under the residential disability service contract have information provided by Tikura Trust. An assessment is completed pre admission and assessments are ongoing. The six of six family members at interview report their family members receive care that meets their needs adequately.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The 10 person centred care plans (five hospital and five rest home) reviewed have a standardised format that is individualised to meet the resident`s assessed needs. Each resident`s plan identifies the resident`s needs and care requirements, with specific plans to respond to reducing falls, increase mobility and or gain weight if required. The 10 of 10 records reviewed demonstrate integration inclusive of input from care, activities, GP medical and allied health services. Short term care plans are developed as required and when fully actioned the care plans is signed off.

The six of six health care assistants at interview report they receive adequate information to assist the continuity of care both in the rest home and in the hospital. The handover observed includes updates of all residents, diabetic monitoring, changes in residents observed, full blood counts and /or urine test results if significant for a resident. Staff however, had to be alerted to one hospital level resident in the rest home who was found in a distressed state and was unable to summon assistance. There are seven hospital level residents placed in the rest home. These residents are located in different wings of the rest home presently.

The six of six family members and 13 of 13 (two were younger disabled and could not speak very well) report satisfaction with the quality of care provided at this service. One resident states `it is the best place they has been in`.

The District Health Board contract requirements are met.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)
Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)
Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)
Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

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

Attainment and Risk: FA

Evidence:

The service has adequate dressing and continence supplies to meet the needs of the residents in the hospital and the rest home. The two registered nurses report that education is provided on a regular basis. Wound-care products are used that are cost effective and evidenced based information is readily available. The 10 person centred

care plans reviewed (five rest home and five hospital) record interventions that are consistent with the residents` assessed needs and desired goals. Observations on the day of the audit indicate residents receiving care that is consistent with the documented resident`s needs.

The six of six family and 12 of 12 staff report that the service meets the needs of the residents. The six of six health care assistants interviewed report they have access to the care plans and the registered nurses keep them updated and well informed. All registered nurses and health care assistants are rotated both in the rest home and the hospital. The staff do not stay in the one facility for lengthy periods of time but they get to know the resident`s well.

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: PA Low

Evidence:

The diversional therapist employed for forty hours each week has been employed at this service for six months. The diversional therapist (DT) graduated three years ago from the New Zealand Society for Diversional Therapy (NZSDT) training. The hours of work are flexible and include some weekend work. Special days are celebrated. The DT interviewed meets with other facility activities co-ordinators on a regular basis and is always increasing ideas and knowledge for facilitating the programme.

The activities programme is not obviously displayed in many areas of the rest home and the hospital. In the hospital there is a large green board with black writing that is difficult to read. The DT has many ideas and currently maximises the resources available. The DT has developed and implemented a training session for the health care assistants to ensure they understand what diversional therapy actually is and the benefits and what recreation is.

Attendance records are maintained. The programme is available for review. The programme evidences varied activities with music, TV shows, toss balls/talk, bible study, church services, memory stories and numerous outings. The next planned outing is the concert bands` annual concert at the University of Auckland 8 October 2014. Happy hour is held regularly.

A newsletter is evident and evidences the programme and special events. A van is hired presently while a decision by the service provider is made, as to whether a van is to be purchased. A car is currently available for appointments and can take a maximum of three residents on an outing. There is one area of required improvement in relation to planned activities for the under 65 year olds (seven residents) not being adequately provided to meet their individual needs.

Feed-back was sought from thirteen of thirteen residents and six of six family and the responses were positive. The activities are well attended as witnessed on the second day of the audit with a visiting pacific youth group singing.

The District Health Board contract requirements are partially 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: PA Low

Evidence:

Residents interviewed (13 of 13) do not necessarily feel their activities and recreational needs are being effectively met in all areas of service delivery. The person centred care plans and activities plans do not reflect how the needs of individual residents will be met in particular for the younger disabled residents.

Finding:

Activities are documented as being provided in both the hospital and the rest home. However, the activities provided for the younger disabled persons is difficult to validate for the seven residents receiving services.

Corrective Action:

To ensure the programme is developed and implemented to meet the needs of all residents.

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

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

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

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

Attainment and Risk: FA

Evidence:

Nursing reviews and assessments, medical and specialist consultations, and admissions and discharge summaries are clearly documented in the 10 of 10 residents` records reviewed. Documentation reflects the evaluations of the person centred care plans in both the rest home and the hospital conducted six monthly and more often if required. Interventions are changed accordingly to ensure all needs and goals set can be effectively met.

If a resident is not responding to the service interventions being delivered, or their health status changes, then this is discussed with the GP and this is validated by the two registered nurses interviewed. Short term person centred care plans are in some of the records and are utilised for wound care, skin tears, infections, mobility, changes in food and fluid intake and skin care. These processes are clearly documented on the short term care plan, medical and nursing assessments and in the individual resident`s progress notes.

The six monthly multidisciplinary meeting is available and reviews sighted in the 10 of 10 resident`s records. The two registered nurses discuss how they are responsible for organising the multi-disciplinary reviews for the residents they are allocated on the schedule. Allied health professionals input is sought as required. Family input is evidenced on the review as the form is signed off by the registered nurse concerned with the review and the family/resident. Any correspondence with the family/whanau is recorded on the communication with family page in the front of each resident`s records.

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:

A resident is provided with options if required to access other health and disability services when required. There is one GP who is responsible for the 93 residents at this facility. The GP was interviewed by telephone. The GP is able to arrange a referral to a specialist for another opinion when it is necessary. The referrals are responded to reasonably promptly when the referral is sent. Records of the process is maintained as confirmed in the resident records reviewed. Evidence of copies of referrals to urology, orthopaedics, radiology or portable x-ray, cardiology are retained in the residents' records.

Transportation and escorts can be arranged to take a resident to an appointment if family are unable to accompany them.

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:

If a resident`s condition or current health status changes the GP is notified. Should a resident require higher level hospital or dementia care, a referral is sent to the NASC service for a reassessment to be performed. On approval, assistance is provided to families in the event of this occurring, to find a suitable service provider or a rest home level resident may change to hospital level care.

If a resident`s health status changes and requires transfer to the DHB the GP contacts the service required in the first instance and then the transfer is arranged by the nursing staff. In an emergency situation the resident is transferred immediately and the GP is informed and the RN on call. The transportation is arranged by the staff on duty. The yellow envelope system is used as per the ADHB protocol documented and verified by the business and care manager. The family and/or representative would be contacted and this is documented on the communication family record sheet in the front of the resident`s individual record. The transfer information providing family contact details, any identified risks, infection control issues if any, mental state, wound and skin care and the reason for admission and relevant clinical history and a full assessment of usual daily living abilities. A copy of the medication record is included in the transfer documentation.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The Oceania Group policies and procedures for medication management reviewed reflect safe and timely medicine management. Procedures comply with current legislative requirements. Pharmacy reconciliation for each resident is performed when the six monthly multidisciplinary reviews occur and for each new admission to this service. If a resident is admitted to the DHB and is discharged back to the facility a reconciliation of medications is completed by the pharmacist to ensure any changes in medication are recorded and dispensed appropriately. Twenty medication records (ten rest home and ten hospital) are available for review. The robotic medication system is utilised. The contracted pharmacy is responsible for the dispensing and checking of the medication prior to delivery. The registered nurses check all medications when delivered.

The controlled drugs are stored appropriately and the controlled drug medications are checked weekly on a Monday morning by two registered nurses. Medications are only administered both in the rest home and the hospital by the registered nurses who have each completed medication competencies and ongoing education in relation to medicine management as sighted in the education records.

The lunch-time medication rounds were observed both in the rest home and the hospital. The registered nurses wear navy and white aprons to identify that they are responsible for the medications and are not to be disturbed while performing this role. Signature lists of all staff and the GP are available. Three medication folders are available. The medication records have photo identification for each resident. Consent is obtained on admission. The medication record also has pictures of each medication for checking purposes. The record and signing sheets are generated monthly by the pharmacy. There is clear evidence of the three monthly reviews by the GP. These are dated and signed off by the GP. There is one observation that the stop dates are not included in the short term medication records but all are signed off and ruled through neatly. The clinical manager ensures the medication reviews occur in a timely manner and has developed a schedule for this purpose which is effective.

The temperatures of the medication fridges is monitored and the records are available. A list of any residents self-medicating medication is documented in the front of each medication folder. The GP signs off the competency form for each individual resident. This is reviewed three monthly when the resident`s medication is reviewed by the GP.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service won the 2013 Excellence in food preparation for care homes and hospitals and the certificate is displayed in the entrance to the facility. The kitchen team leader interviewed is very experienced and has been in this present position for eighteen months. The kitchen team leader ensures the kitchen is covered by staff each day. There are four staff on each day and five when possible. There are two assistant chefs and kitchen hands employed. Daily there is a baker, two chefs and one kitchen hand. All staff have completed appropriate food handling and food preparation courses required by Oceania. Training continues on site on a regular basis. The kitchen is large in size and very functional. Waste management systems are in place. There is appropriate equipment and resources available. The kitchen team leader discussed the cleaning schedule developed and implemented.

The kitchen team leader is responsible for the food ordering, online ordering, meat order, vegetables and fruit and dry stock foods being purchased. All deliveries are checked on arrival and stored appropriately. Dry stock is rotated. No food is stored at ground level.

The menu is on a four week cycle and the service is currently on week two. The Oceania Group dietitian is responsible for reviewing the menu plans sighted. The dietitian has a valid annual practising certificate dated expiry 31 March 2015. The menus are displayed in each area of service. Food temperature and fridges and freezers are monitored daily by the kitchen staff and records are accurately maintained. There is one walk-in freezer, two fridges and a walk-in chiller. There is a temperature dial on the walk-in freezer and chiller and the maintenance man checks this weekly as a back up to the staff checks.

Food is taken to the hospital and the rest home services in bain maries and served by staff. Staff observed to be wearing personal protective equipment gloves, hats and aprons. The clinical manager was involved with serving the lunchtime meals in the hospital dining room.

Catering for special functions can be arranged with the kitchen team leader. A special function at the facility chapel was provided on one of the audit days Baking occurs daily so birthday cakes are made especially for the resident`s on site. Information about special diets identified on admission by the registered nurses completing the nutritional assessments for the resident if forwarded to the kitchen team leader. Vegetarian, gluten free, no chicken or no fish are acknowledged and the preferences of all residents are considered on a daily basis. Cultural needs and ethnicity is respected and appropriate foods are served. Supplement drinks/beverages are provided. Portion sizes, lip plates, soft mouli foods are documented on the whiteboard in the kitchen.

The kitchen team leader is also responsible for preparing the meals for another facility which currently has 60 residents.

Positive feedback from the resident/family surveys is available as well as from the interviews of all residents and families involved. There have been no complaints about the food service.

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 was observed in all high risk areas.

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

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A current Building Warrant of fitness is posted in a visible location at the entrance to the buildings (expiry date 30 April 2015). There have been no building modifications since the last audit however there are room refurbishments as these are required. There is a planned maintenance schedule implemented.

There are two distinct buildings at Everil Orr: i) a rest home building with seven residents identified as requiring hospital level care with two levels (noting that the lower level can only cater for rest home residents who are mobile particularly at one end where there is a short flight of stairs between levels), ii) a hospital building on two levels. The two buildings are accessible via an outdoor path. Within each building, there are wings. Residents use rooms that suit their abilities and needs e.g. more independent residents use rooms in the lower ground floor of the rest home and hospital buildings (Refer 1.3.3.1).

The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programme two yearly and this is up to date. There is an annual BV Medical test and tag programme that is current.

Interviews with six of six health care assistants, two registered nurses and the clinical manager confirm there is adequate equipment.

There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required.

There are safe outside areas that is easy to access for residents and family members. The front garden is being upgraded to allow residents using mobility aids to have better access.

The District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

There are adequate numbers of accessible toilets/bathing facilities. This includes full ensuites, visitors' toilets and communal toilets conveniently located close to communal areas. The communal toilet facilities have a system that indicates if it is engaged or vacant. Some have locks on the doors and staff can unlock doors if they have to.

Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

Thirteen residents (seven rest home and six hospital) and six family members (three hospital and three rest home) interviewed report that there are sufficient toilets and showers with a number of rooms having their own ensuite.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

Rooms downstairs in the rest home are checked to ensure that only residents who are able to access stairs and the lift are able to reside there. This is also confirmed on interview with three residents who live in the downstairs area. There are two lifts and both are operational with checks completed by an external company.

Equipment is sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists and staff confirm that there are always two staff providing support when using the lift. Residents requiring use of a hoist were sighted on the day with staff supporting them in their rooms with sufficient space for all.

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

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

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 the rest home building and in the hospital building and these are large with appropriate floor coverings in each part e.g. carpet only in the lounge area of the room. All areas are easily accessed by residents and staff. There are smaller dining and lounge areas throughout both the rest home and hospital buildings. 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 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. Activities for a large group are held in the hospital lounge with residents from the rest home being supported to attend as observed on the days of the audit.

The lounges are also accessible, lounge which is used for activities and a specific area for the hairdresser is located in the hospital area. Residents in the rest home building are able to be taken over to the hair dresser as required.

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: PA Low

Evidence:

Large laundry items such as towels and linen are subcontracted to another Oceania facility service with personal laundry washed and dried on site. There are a number of laundry rooms in both the rest home and hospital buildings with these located in wings. All rooms bar one have either external windows or ventilation. Five residents specifically asked state that the laundry is well managed and they get back their clothes.

The cleaners are observed to have the trolley in the room with them when cleaning and all have appropriately labelled containers. Ecolab products are used with training around use of products last provided in 2014. Cleaning is monitored through the internal audit process with no issues identified in audits last completed in 2014. Chemicals and cleaning cupboards are locked away in both the rest home and hospital buildings.

The District Health Board contract requirements are partially 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: PA Low

Evidence:

There are a number of laundry rooms in both the rest home and hospital buildings with these located in wings. All rooms bar one have either external windows or ventilation.

Finding:

One laundry room in the rest home building does not have external ventilation.

Corrective Action:

Ensure that all laundry rooms are ventilated.

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

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

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

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

Attainment and Risk: FA

Evidence:

An evacuation plan was approved by the New Zealand Fire Service on 7 September 2003 with a separate certificate for the hospital and rest home buildings. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly with the last drill conducted as per schedule in 2014. 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. 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. A backup generator for emergency lighting is in place in the hospital building and access to batteries and torches in the rest home building.

An electronic call bell system utilises a pager system. There are call bells in all residents' rooms, residents' toilets, and communal areas including the hallways, dining room and hairdressing space. Call bell checks are routinely completed (Refer 1.3.3.1).

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

One fire alarm was covered with a glove by a painter for a morning however this was noted by the maintenance staff and removed. The business and care manager states that the paint fumes set off the fire alarms. The painter repaired three ceilings in the rest home that were noted to have peeling paint. All other surfaces are well maintained (refer 1.4.6.3).

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)
The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA

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.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Oceania Group policies and procedures are in place and are accessible to guide staff in restraint minimisation and safe practice. Restraint is actively minimised as evidenced in the restraint register reviewed. The register is kept in the hospital for the total facility inclusive of the rest home. The policy reviewed identifies enablers are voluntarily used following an appropriate assessment. There is only one resident (bed side rails used for re-positioning) using an enabler. No restraint is used as evidenced in the restraint register. The enabler use is reviewed during the multidisciplinary reviews six monthly. The restraint co-ordinator an experienced registered nurse has been in this role for one year. The restraint co-ordinator at interview explains the role and the responsibilities and the records maintained.

Restraint meetings are held monthly and the minutes of meetings folder is available and is reviewed. Four staff are involved and the meeting is chaired by the clinical manager. The restraint committee consists of the clinical manager, two RNs and two health care assistants. The GP is responsible for signing off the consent forms.

All staff complete restraint training as part of the orientation programme. Training is ongoing and occurs annually. Restraint competencies are completed and de-escalation strategies are discussed. Only five staff are yet to complete restraint training for 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection prevention and control programmes aims to prevent the spread of infection and reduce the risks to residents, staff and visitors. Policies and procedures are aligned with current accepted practice and clearly meet the infection control standard requirements. The policies and procedures are reviewed two yearly. The infection control co-ordinator (ICC) interviewed is new to this position and is supported by the clinical manager. A job description is available for this role. The ICC is an experienced registered nurse and at interview is aware of the responsibilities involved. The infection control programme is reviewed annually and signed off by the operations manager. There is a system in place for infection control matters and for reporting information internally and to head office for Oceania Group as documented.

Staff and visitors suffering from infectious diseases are advised not to enter the facilities. Staff interviewed, two registered nurses and six health care assistants are aware of when not to come to work and when to return when they have been off duty sick. Sanitising hand gel dispensers are observed throughout the facilities and there is adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are encouraged to stay in their rooms if required. Staff interviewed are able to demonstrate good infection prevention and control techniques and awareness of standard precautions. The services are prepared for outbreak management but the ICC reports there has been no outbreaks since the last audit. Residents with consent obtained have been vaccinated for the flu vaccination earlier in 2014. Consent forms and evidence of administration is sighted in the 10 resident records (five rest home and five hospital) reviewed.

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:

The infection control committee comprises of one health care assistant, the kitchen team leader, household supervisor and two registered nurses one of whom is the designated infection control co-ordinator. The committee is appropriate for this service. Committee terms of reference is documented in the infection control manual and is reviewed two yearly. The role of the committee is defined, inclusive of access to specialist and expert advice, tasks, quality improvement and meetings to be attended. All staff have completed the infection control workbook at commencement of employment as part of the orientation process and education is provided on an ongoing basis. This is evidenced by sighting the education programme and at interview with the ICC. The ICC demonstrates knowledge and understanding of current accepted good practice in relation to infection prevention and has attended Oceania study days in 2014.

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:

Oceania has comprehensive policies and procedures appropriate for this aged care setting. The policies and procedures reviewed cover all requirements identified in the Health and Disability Services Infection Control Standards 2008. There are clear guidelines for staff on how to manage infections and outbreaks. Observation in both the hospital and rest home identify the implementation of infection prevention and control procedures. Staff demonstrate safe and appropriate infection prevention and control practices.

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:

Infection control education is included in orientation and as part of the ongoing educational programme for 2014. The ICC provides education for all staff on a regular basis. All staff have completed hand washing competencies. On-line training is available on infection control. Registered nurses have received training in wound care management and infection control was held 7 October 2014 with a good attendance recorded. Training is also provided at WDHB and ADHB for the registered nurses. The infection control nurses can be contacted if required or the nurse practitioner in relation to wound care management should this be required. Infection control is discussed at all staff meetings. The infection control meetings are held monthly and topics include sessions on hand hygiene, standard precautions, respiratory etiquette, norovirus and urinary tract infections. The incidents and monthly outcomes are displayed for the staff for the hospital and the rest home and the benchmarking is also available to compare this service against other Oceania aged care services. Staff interviewed (two registered nurses) state they like to see how they compare each month.

All staff have completed hand hygiene competencies and records are maintained.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The service has a system in place to ensure the infection control committee oversees and seek expert advice related to undertaking surveillance of infections to meet the Health and Disability Sector Standard requirements related to the complexity of the facility. Policy states expert advice and specialist advice is available from the clinical microbiologist Labtests Ltd and from the GP. The infection control nurse specialists at WDHB or ADHB can be contacted, if required. The gerontology nurse specialist can be contacted regarding any nursing or resident issues in relation to infection management. The pharmacist contracted to the service is also available for consultation.

The ICC is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g., facility acquired infections are documented to guide staff). Information is collated on a monthly basis for respiratory, influenza, urinary infections, skin and soft tissue, multi-resistant infections (MRI), diarrhoea, eye (conjunctivitis) and other types of infections. Information is collated and analysed monthly and reported back to staff in graph form. This information is displayed around the facility and in the staff room. The information is sent through to head office and is benchmarked with other Oceania facilities. Comparisons and any areas of improvement are documented and used in the infection report and fed back to staff at the staff 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.)*