

Oceania Care Company Limited - Lady Allum

Current Status: 13 October 2014

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

General overview

Lady Allum is part of the Oceania Group. This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Lady Allum provides residential hospital and rest home level care for up to 140 residents with 38 residents requiring rest home level care and 103 residents requiring hospital level care.

The business and care manager has been in the role for three years with clinical managers and a charge nurse providing clinical oversight. Staffing was appropriate to support the needs of residents requiring hospital and rest home care. There was a quality and risk management programme in place.

Seven of seven improvements required at the last certification audit around complaints, internal audits, electrical equipment, hot water temperatures, trial evacuations and back up in the event of an emergency have been addressed.

An improvement was required to ensure that the District Health Board be informed and authorises additional capacity over and above that identified as part of the certification process.

Audit Summary as at 13 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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 13 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.
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Organisational Management as at 13 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.
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Continuum of Service Delivery as at 13 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.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 13 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.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 13 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.
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Infection Prevention and Control as at 13 October 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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 - Lady Allum
Designated Auditing Agency:	Health Audit (NZ) Limited
Types of audit:	Surveillance Audit
Premises audited:	Lady Allum Villlage
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 October 2014 End date: 14 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:	141

Audit Team

Lead Auditor	XXXXXXX	Hours on site	12	Hours off site	8
Other Auditors	XXXXXXX	Total hours on site	12	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXX			Hours	2

Sample Totals

Total audit hours on site	24	Total audit hours off site	18	Total audit hours	42
Number of residents interviewed	11	Number of staff interviewed	19	Number of managers interviewed	3
Number of residents' records reviewed	8	Number of staff records reviewed	12	Total number of managers (headcount)	3
Number of medication records reviewed	16	Total number of staff (headcount)	124	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Wednesday, 30 January 2013

Executive Summary of Audit

General Overview

Lady Allum is part of the Oceania Group. This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Lady Allum provided residential hospital and rest home level care for up to 140 residents with 38 residents requiring rest home level care and 103 residents requiring hospital level care.

There was a business and care manager who has been in the role for three years with clinical managers and a charge nurse providing clinical oversight. Staffing was appropriate to support the needs of residents requiring hospital and rest home care. There was a quality and risk management programme in place.

Seven of seven improvements required at the last certification audit around complaints, internal audits, electrical equipment, hot water temperatures, trial evacuations and back up in the event of an emergency have been addressed.

An improvement was required to ensure that the District Health Board be informed and authorises additional capacity over and above that identified as part of the certification process.

Outcome 1.1: Consumer Rights

Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties and caring for the residents. Information regarding resident rights, access to advocacy services and how to lodge a complaint was available to residents and their family and complaints were investigated. Staff communicated with residents and family members following any incident.

The improvement required at the certification audit around complaints has been addressed.

Outcome 1.2: Organisational Management

Lady Allum had implemented the Oceania quality and risk management system that supported the provision of clinical care and support. Policies were reviewed and business status reports allowed monitoring of service delivery. Benchmarking reports were produced that included clinical indicators, incidents/accidents, infections and complaints.

Staffing levels were adequate in each of the units and interviews with residents and relatives demonstrated that they had adequate access to staff to support residents when needed.

The improvement required at the certification audit around rating, dating, signing off and identification of audit location in the audit records has been addressed.

An improvement is required to ensuring that the District Health Board is notified and authorises numbers of residents over and above the number identified as part of certification.

Outcome 1.3: Continuum of Service Delivery

Lady Allum rest home and hospital systems and processes were implemented to assess, plan and evaluate the care needs of the residents. Staff were trained and qualified to perform their roles and deliver all aspects of service provision. Staff provided team work and continuity of care. The multidisciplinary approach to service delivery worked effectively and efficiently. The registered nurses each of whom were responsible for the person centred care plans being reviewed and maintained. All interventions were consistent with best practice standards. There was an area of required from the previous audit in relation to interventions are this was effectively closed out.

The activities programme was well structured to support the interests, needs and strengths of residents. The activities plan was documented and displayed in all six units and there was an activities staff member in each of the units to facilitate the programme. The development and the implementation of the programme was overseen by the diversional therapist.

The medicine management was implemented safely and in line with best practice and meets legislative requirements. All medications were prescribed by the two general practitioners, stored and administered in a professional manner. All staff had completed medication competences who administered medications. Accurate medication records were maintained. There was evidence of the two general practitioners completing the medication reviews three monthly or more frequently as required.

The food service was provided and managed by a contracted service provider. The menu plans were adhered to and were reviewed annually. Residents` individual dietary needs were identified during the assessment process by the registered nurses and reported to the Chef. Any other changes or requirements were also forwarded to the kitchen staff. Special events were catered for and residents and family/whanau interviewed report satisfaction with the food service provided.

Outcome 1.4: Safe and Appropriate Environment

There was a current building warrant of fitness in place. There was a planned and reactive maintenance programme in place with issues addressed as these arise. Residents and family described the environment as meeting their needs.

Improvements required at the certification audit around checking of electrical equipment, hot water temperatures, trial evacuations and to back up supplies of electricity in the event of an emergency had been completed.

Outcome 2: Restraint Minimisation and Safe Practice

Adequate policies and procedures were documented and there were clear definitions of restraint and enabler. Staff received training on restraint management, enablers and the management of challenging behaviours. De-escalation workshops were held three monthly. Currently there were eight residents using a form of restraint and two using an enabler.

Outcome 3: Infection Prevention and Control

The infection prevention and control programme aimed to prevent the spread of infection and reduce the risks to residents, staff and visitors. Policies and procedures were in line with best practice. One of the clinical managers was the infection control co-ordinator who was well qualified to perform this role. Staff received infection control education as part of the staff orientation programme and this was ongoing as reflected in the education programme.

Surveillance data was recorded, collated and reported to the staff on a monthly basis. The clinical infection control summary sheets were kept on file for all six units at Lady Allum. Analysis and evaluation of data was used to develop any corrective actions required, which were monitored by the clinical manager in a timely manner. Assistance and expert advice was sought from the contracted pharmacist and the laboratory used for this service.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	19	0	1	0	0	0
Criteria	0	49	0	1	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	30
Criteria	0	0	0	0	0	0	0	51

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.1: Governance	The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low			
HDS(C)S.2008	Criterion 1.2.1.1	The purpose, values, scope, direction, and goals of the organisation are clearly identified	PA Low	The service has not received HealthCERT authorisation to have an extra resident in the facility and	Ensure that HealthCERT provides authorisation for any extra residents in the facility that	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and regularly reviewed.		the District Health Board has not been notified.	take numbers of residents over the certified number and that the District Health Board is notified.	

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

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 and in the resident files.

Family contact is recorded in residents' files – sighted in eight of eight resident files reviewed (four rest home and four hospital).

Interviews with seven family members (five hospital and two rest home) confirm they are kept informed. Family also confirm that they are invited at least six monthly to the care planning meetings for their family member with this confirmed on the multi-disciplinary form.

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

Interpreter services are available when required from the District Health Board. There are no residents currently requiring interpreting services and all residents interviewed (11 of 11 including seven in the rest home and four in the hospital) confirm that staff are approachable and communicate well. One residents has signage on the door in XXXXX but speaks English and does not need an interpreter.

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

Staff have had training around communication in 2014 with a number of sessions offered during the year to accommodate staff.

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 1.1.13: 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 Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes time-frames for responding to a complaint. Complaint's forms are available in each unit – hospital and rest home. There is also a 'mail' box and anyone can put a note in the box with follow up according to the complaints policy.

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

Two complaints lodged in 2014 were selected for review. There is documented evidence of time-frames being met for responding to these complaints with documentation indicating that the complainants are happy with the outcome.

Eleven of eleven residents (seven rest home and four hospital residents) and seven family members (five hospital and two rest home) state that they would feel comfortable complaining.

There has been one complaint with the Health and Disability Commission (HDC) in January 2014 with a letter from the HDC in March 2014 confirming that HDC does not wish to take any further action on the complaint.

All complaints are captured in the complaints register as confirmed on interview with two family who state that complaints made have been addressed and recorded appropriately. The improvement required at the previous audit has been addressed.

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: PA Low

Evidence:

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

Communication between the clinical and quality manager and the business and care manager takes place on a monthly basis with more support provided as required (confirmed by the quality and clinical manager and business and care manager interviewed).

Oceania has a clear mission, values and goals. The vision is to be the provider of choice for senior New Zealanders of care and lifestyle options in a way that meets and exceeds the expectations of our residents, staff and stakeholders. The mission is 'we provide excellent contemporary care that reflects our residents' individuality and their right to choice, respect and dignity. We provide a positive and welcoming environment in which our residents are encouraged and supported to improve their quality of life'.

The facility can provide care for up to 140 residents for hospital level of care (100 beds available), rest home (25 beds available) or medical level of care. During the audit there are 141 residents living at the facility including 38 residents at rest home level of care and 103 residents at hospital level of care. There are 15 assisted living suites which are categorized as dual-purpose beds. One assisted living suite has a couple in the suite which accounts for the extra resident currently in the facility. The assisted

living suite is large enough to accommodate both residents with a full ensuite and kitchenette facilities. Both residents in the suite are at rest home level care. The service has not received HealthCERT authorisation to have an extra resident in the facility and the District Health Board has not been notified.

The business and care manager is responsible for the overall management of the facility. The business and care manager has been in the role for three years with a background as a nurse in Australia and manager of a MRI health screening service in England. The business and care manager is supported by two clinical managers and a charge nurse who provide oversight of the clinical aspects of the service.

The District Health Board contract requirements are partially 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: PA Low

Evidence:

The facility can provide care for up to 140 residents for hospital level of care (100 beds available), rest home (25 beds available) or medical level of care. During the audit there are 141 residents living at the facility including 38 residents at rest home level of care and 103 residents at hospital level of care. There are 15 assisted living suites which are categorized as dual-purpose beds. One assisted living suite has a couple in the suite which accounts for the extra resident currently in the facility. The assisted living suite is large enough to accommodate both residents with a full ensuite and kitchenette facilities. Both residents in the suite are at rest home level care.

Finding:

The service has not received HealthCERT authorisation to have an extra resident in the facility and the District Health Board has not been notified.

Corrective Action:

Ensure that HealthCERT provides authorisation for any extra residents in the facility that take numbers of residents over the certified number and that the District Health Board is notified.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

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

All staff interviewed including five of five health care assistants, the activities coordinator, the maintenance staff, the clinical managers, charge nurse and four of four registered nurses report they are kept informed of quality improvements.

There are monthly meetings that include the following: multidisciplinary, communication, activities, health and safety, quality improvement.

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. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated. The two maintenance staff confirm their role in managing and addressing hazards.

The organisation holds a current ACC Work Safety and Management Practice tertiary level accreditation.

There is a Community Connect newsletter from the organisation.

The last resident/family satisfaction survey is collated (completed last in August 2013) and the service has acted on any recommendations identified. A collated report from the survey indicates that residents and family are satisfied overall.

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 noting that improvements identified as being required have a corrective action plan documented and evidence of resolution of issues documented in meeting minutes particularly in the quality and risk meeting minutes and other meeting minutes when these are documented.

There are meetings held across the service including monthly quality and risk meetings, health and safety, registered nurse, health care assistant, housekeeping, weights committee, staff, food service, maintenance. There are monthly restraint meetings. There are a number of opportunities for residents and family to have input into the service

through three monthly meetings (hospital and rest home) and a new resident/family welcome group held two monthly. There is an interdisciplinary service continuum meeting which includes health professionals including doctors, pharmacists, occupational therapist, clinical team, podiatrist.

The improvement required at the previous audit around rating, dating, signing off and identification of audit location in the audit records has been addressed.

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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.2.3.6 (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.

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

Finding:

Corrective Action:

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

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 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 selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared through the monthly meetings with documentation of incidents which are then graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. The results are displayed in the staff room and registered nurses and health care assistants describe sighting these and reviewing trends.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All registered nurses, the clinical managers and charge nurse hold current annual practising certificates. Visiting practitioner's practising certificates include the general practitioner, dietitian, podiatrist and physiotherapist and a review during the audit confirms that these are current.

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

Police checks are completed – sighted in all employee files reviewed apart from those staff who have been employed more than five years ago.

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 health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and health care assistants who administer medicines to residents. Other competencies are completed including hoist, oxygen use, hand washing, wound management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower. Completion of the annual competencies now occurs at the time of the performance appraisal for each staff member and this ensures that all are up to date.

Mandatory training is identified on an Oceania wide training schedule with training occurring over the year for staff. There is a lot of one to one training with the business and care manager also visiting night staff to ensure they receive training. Training topics are repeated during the year so that all staff have an opportunity to participate. There are folders of attendance records and training with a spreadsheet maintained with all training included. Staff training records are maintained in a format that enables verification of completion of identified mandatory training by relevant staff.

The five health care assistants state that they value the training. Education and training hours exceeds eight hours a year for all staff reviewed.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

There are six distinct units including four hospital units, one rest home unit and one mixed (assisted living suites). The units have between 24 to 27 residents in each with the exception of the assisted living suit unit which has a total of 15 rooms (16 residents). The rosters indicate that there is a registered nurse in each hospital unit with four healthcare assistants morning and afternoon (two health care assistants full shift and two short shift of either six or four hours on each shift) and one health care assistant overnight on each unit.

In the rest home unit, there is a registered nurse and two health care assistants morning and afternoon (one of the health care assistant is a short shift in the afternoon) and one caregiver overnight. In the assisted living suites, there are two health care assistants in the morning and afternoon and one overnight. The registered nurse in the rest home unit also covers the assisted living suites in the morning and afternoon and the registered nurses from the hospital units cover overnight. The arrangement of staffing is appropriate to the needs of the resident as confirmed by the clinical manager and the business and care manager interviewed.

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

There are currently 124 staff including the business and care manager, two clinical managers, charge nurse, 19 registered nurses, six activity coordinators (one in each unit), 23 housekeeping and maintenance staff and 68 health care 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:

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

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

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

Attainment and Risk: FA

Evidence:

There are policies and procedures in place to identify how residents receive timely, competent and appropriate services to meet the needs as identified in the assessment processes. The registered nurses and the two clinical managers interviewed identify that the development of the long term care plan is a partnership process. The registered nurses work collaboratively with the resident and the resident's family /whanau, advocate or other healthcare providers to complete the comprehensive care plans sighted.

The initial care plan is documented within 24 hours of admission taking into consideration the needs assessment service co-ordination service's NASC assessment and the comprehensive admission assessment for Oceania. The eight of eight resident records (four hospital and four rest home) have all been reviewed six monthly or more often if required. There is clear involvement and evidence of the consultation sought with the resident, the multidisciplinary team, resident's family/whanau and/or advocate. The family/whanau interviewed seven of seven (five hospital and two rest home) verified that they are always invited to participate in the evaluations.

Handovers are provided by the registered nurses between each shift and this was observed in the hospital. Each stage of delivery is undertaken by qualified and suitably skilled staff. There is an appropriate education programme for staff that covers the essential components of the organisation and service delivery. A record of all participants is maintained for all in-service provided by the clinical managers and the charge nurse.

The registered nurses are responsible for the comprehensive nursing assessment for each allocated resident on admission to develop the initial and long term care plans, evaluate and review care plans in consultation with the team and family. The GP conducts the medical assessments and reviews the resident's condition. The healthcare assistants provide the majority of the personal cares for the residents. Three health care assistants interviewed confirm that team work is encouraged and continuity of care is promoted at all times. One of the two GPs who is interviewed cares for the majority of the residents. The GP visits regularly and is on call seven days per week and has covered this facility for many years. Strategies to manage the after-hours services are in place.

The eight of eight resident records reviewed evidence the assessment process, set goals for the resident that identifies the physical, psychosocial and cultural aspects for each resident. The service uses recognised assessment tools such as waterlow, tinetti gait and balance, falls risks assessments, continence assessment and others.

The two clinical managers have completed the interRAI training.

The District Health Board contract requirements are met.

Tracer Methodology Rest Home:

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

Tracer Methodology Hospital:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.5: 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:

This was an area of required improvement from the previous audit which has been effectively closed out. There is evidence in the eight of eight resident records reviewed of resident files being integrated with dividers between each section. The use of short term care plans to promote continuity of service delivery was encouraged by staff interviewed. The short term care plans and long term care plans have been updated as required and are all current.

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:

Two registered nurses and one charge nurse interviewed explained the use of the person centred short term care plans. Short term plans are used for problems that can be resolved within about four weeks. The eight of eight long term person centred care plans (four hospital and four rest home) reviewed record interventions that are consistent with the residents' assessed needs and desired goals. The family is notified if there is any changes to the care plan and this is recorded on the family communication record sheet in the individual resident's record. Observations on the day of the audit indicate residents receiving care that is appropriate and consistent with the individual resident's needs. Seven family (five hospital and two rest home) and 11 residents interviewed (seven rest home and four hospital) interviewed report that the service meets the needs of the resident. The healthcare assistants interviewed report that the care plans are up to date and do reflect the individual resident's needs and are able to be followed easily.

There was an area of required improvement in the last audit (1.3.5.2) in relation to the long and short term care plans not being updated when changes occurred and this has been verified in eight records reviewed and has been effectively closed out.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are six units to prepare and plan activities for at Lady Allum rest home and hospital. There are five staff employed to facilitate the activities programme across the six units and one activities co-ordinator team leader. The activities assessments and activities plans are developed and implemented for each unit by the activities staff member for each particular unit for example Nikau & Salmond, Kowhai, Aurora & Kirkwood and Arohanui. The programmes are displayed for the week with times and activities documented and the venue for the activity as well is documented. All activities are site wide. Everyone is welcome to attend both rest home and hospital programmes. Each resident receives a copy of the programme as well as each unit. There is a chapel and services are held every first Sunday of the month. There is a chaplain on site at Lady Allum who works part time.

Activities are held in the lounge at the end of each unit and one special activities room between Nikau and Salmond and there is a functions room which is large for concerts and happy hour. The activities staff member interviewed is leaving the next day but was able to provide adequate information about the implementation of the activities programme. This activities co-ordinator works thirty hours a week and has been in this role for eighteen months. The activities programme was observed in Nikau/Salmond which was catering for 57 residents are rest home level except for two residents that are hospital level. When planning the programme five categories are used to cover the programme and to plan the activities such as fixed activities and a bus trip. The activities staff get together weekly to discuss, debrief about an activity with constructive communication. The programmes reviewed ensure the strengths, skills and interests of residents are maintained. The activities plans are reviewed at the same time the care plans are reviewed and this system works effectively.

The bus trips are planned in advance and usually the designated driver and two staff take the residents out to the theatre or a show. Attendance records are maintained. Residents are documented if unwell or have visitors and do not come out on an activity. There is a bus list when an outing is arranged. The van is a mobility van, holds eight people at a time and has a hoist. The activities newsletter is described by residents and the families interviewed as highlighting events that are scheduled. The resident meeting dates are included in the newsletter.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policy identifies that care plans are evaluated if there is a change in the resident's condition and that they are evaluated and reviewed six monthly. Care plan review is six monthly but more often if required or if there is a change in the condition of the resident. Multidisciplinary input is considered for all residents six monthly with reviews. Reviews occur earlier if there is a change in the resident's status. Interventions are changed if required to ensure all needs and goals set can be effectively met. All evaluations are recorded, dated and signed by the registered nurse undertaking the review.

If a resident is not responding to the services interventions being delivered, or their health status changes, then this is discussed with their GP and the GP interviewed validated this information. Short term care plans are sighted for wound care, infections, changes in mobility and changes in food and fluid intake, and/or skin care and pressure area risk. These processes are clearly documented on the short term care plan, medical and nursing assessments and in the residents' progress records. The resident/family/whanau communication record sheet is completed in the front of the record if the family are notified. If progress is different from expected, or for information provided or communicated to the family/whanau.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a detailed medicine management policy that is reflective of current safe practice. The policy identifies that staff who administer medicines must be competent. Procedures comply with current legislative requirements. Medication reconciliation processes are clearly described. Pharmacy reconciliation of each resident's medication record is undertaken at least six monthly. The pharmacy also audits the medication onsite six monthly, inclusive of the imprest system and the controlled drugs, and this was able to be evidenced when reviewing the controlled drug system. The controlled drugs are only stored in one of the six medication rooms available throughout the rest home and the hospital units. The controlled drugs are checked every Tuesday by two registered nurses. A stamp is used to verify this has been completed. The blister pack robotic system is utilised and the four registered nurses interviewed report this works well for all areas of service.

The medication is delivered every two weeks and is checked in to the service by two RNs. Registered nurses give out the hospital residents medication and a registered nurse oversees the senior healthcare assistants giving out the medications in one rest home unit. All staff who administer medications have completed medication competencies and this is completed annually. The clinical managers maintain records of health professionals current APCs and this includes the two GPs and the pharmacist of choice, the podiatrist, physiotherapist and the Oceania dietitian.

The lunchtime medication rounds are observed in the rest home unit and a hospital unit. The two staff involved managed professionally and safely. Medication records 16 of 16 (eight hospital and eight rest home) are dated, signed, and there is evidence of three monthly reviews occurring by the GPs. Standing orders charted by the two resident GPs are reviewed yearly.

Bright alert stickers are used to highlight allergies or sensitivities if known. Photo identification is on each page of the medication records is evident. There are different coloured signing pages in the medication records sighted such as red for controlled drugs, PRN medication is on a yellow record sheet, orange is for Warfarin administration and pink for antibiotics.

Each registered nurse is responsible for one wing. In the rest home unit the healthcare assistants advise the RN if regular medication is required for ordering purposes. There is a separate signature specimen page for the registered nurses, GPs and bureau staff. There is a policy for residents who choose to self-medicate and who are deemed competent to do so. There is only three residents that are self-medicating. There is a self-medication audit tool that is used to ensure competencies and the individual residents are reviewed by the GP every six months. The staff can ring the contracted pharmacy anytime with any queries. The GP states at interview that there is effective communication between them and the registered and senior staff and the pharmacists from the contracted pharmacy.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The food service is contracted out to a catering service. The same company has managed this area of service delivery since 2009. No staff employed by Lady Allum work in the kitchen. The contracted service performs their own internal auditing schedule, menu plans, monitoring equipment and Health and Safety inclusive of menu plans and food safety. The cook interviewed has been in this position for three and a half years. The cook verifies that in-service education is available. The catering manager interviewed has 13 staff to be responsible for. The catering manager orders all food stuffs and arranges all training, manager in the kitchen and report to head office. There is a Bain Marie for serving all meals. Menu sheets are completed daily for each meal time. Menu plans are reviewed by the Oceania Dietitian. Special diets can be arranged for residents. Cultural needs are taken into consideration. Personal protective equipment is used in the kitchen by staff and this was visible when staff are serving up the meals at lunchtime. Seven of seven families and eleven residents (seven rest home and four hospital) report they enjoy the meals. Birthdays and special events are catered for by the catering service and theme days for the activities programme are also catered for if required.

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.

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

Criterion 1.3.13.5 (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.

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 15 March 2015). There have been no building modifications since the last audit.

There is a planned maintenance schedule implemented and the two maintenance staff confirm implementation of this.

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

The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programme and this is up to date (last completed September 2014) with BV Medical also completing a check of equipment in September 2014. The improvement required at the previous audit has been addressed.

The District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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 an adequate number of communal toilets and shower rooms in the service. Communal toilets and showers are spacious enough to be able to use mobility aids, shower stools and other appropriate equipment to tend to the resident's personal hygiene requirements. There are engaged/vacant signage on the toilet/shower doors. Handrails are appropriately placed to support the resident. The residents interviewed state the staff are respectful and ensure their privacy and dignity is maintained when attending to their personal hygiene requirements.

The hot water temperature in resident areas are maintained at 44-45 degrees Celsius including water temperatures in the Arohanui unit. The improvement required at the previous audit has been addressed.

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 1.4.7: 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 emergency policy and emergency plan is sighted that includes disaster awareness, robbery, bomb threat, hazards and threats, earthquake, tsunami, volcanic eruptions, storms, water damage, flooding, power failure. A security policy is sighted. Night staff are required to complete security checks. There are latches on windows.

Emergency training is conducted during orientation. Induction includes health and safety, hazardous substances, call bell system and emergency planning including an orientation to the emergency procedures.

The approved fire evacuation plan is sighted.

There is a staff member on each shift who has a current first aid certificate. The register of first aid certificates is sighted. There is a call bell system throughout the building. Call bells are checked monthly.

There is evidence in training records that fire and evacuation training has been provided twice in the last 12 months (December 2013 and June 2014). All staff have attended the training and an external contractor (fireman) attends the training to ensure that policies are adhered to. The New Zealand Fire Service is also notified prior to the evacuation. Staff interviewed including five health care assistants are able to describe emergency procedures. Staff are required to attend emergency training (compulsory) at least annually with training records indicating that the majority of staff have attended. The clinical managers, charge nurse and the administrator follow up with staff to ensure they have attended. The improvement required at the previous audit has been addressed.

There is a civil defence room with equipment checked as per the schedule. This includes torches, extra blankets, oil heaters and radios. There are extra continence products available and food supplies to last at least for three days. There are two large water tanks with water gravity fed that is able to be used in an emergency (6325 litres) and 160 litres of bottled water also available. There is a BBQ with full gas bottles and emergency power that can last for two hours. The business and care manager states that a generator would be hired in the event of an emergency for further emergency lighting etc. The improvement required at the previous audit has been addressed.

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.)*

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 restraint minimisation and safe practice policies and procedures are available to guide staff. There are currently eight residents using a form of restraint and two using an enabler. This is evidenced from the monthly restraint monitoring form dated the 30 September 2014. There are 141 residents at this facility and the figures provided are an excellent example of restraint minimisation in a large care facility. The restraint committee meet monthly and discuss each individual resident using a form of restraint or an enabler. Staff interviewed are fully informed of the differences and that an enabler is used as a voluntary request. The GP and approval committee sign the required Oceania documentation when required. Education is provided and de-escalation techniques were provided as part of a restraint and de-escalation workshop held for all staff if possible to attend through the year in February, May and August and annually when the annual appraisals are performed. The restraint co-ordinator is a qualified occupational therapist. A restraint meeting is held monthly.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Standard 3.5: 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:

There is a surveillance system set up which is well managed by the appointed infection control co-ordinator (ICC). The clinical CPI summary sheet is completed monthly by the registered nurses in each of the six units. The laboratory and the contracted pharmacist send relevant information on infections and antibiotic usage each month which is significantly beneficial when collating the data.

The ICC is an experienced clinical manager/ registered nurse who is completing a Masters of Nursing this year. The surveillance system is robust and data is collated and analysed and reported back monthly in graph form. Information is used for benchmarking with other Oceania facilities. Staff receive a copy which is displayed in the staff room and in each unit. Monthly comparisons can be viewed. Staff (four registered nurses) interviewed found this approach is more clearly defined and can be comprehended more easily. The results of surveillance are reported back to management for the quality meetings. The surveillance programme is adequate for the nature of this aged care residential service. Any improvements or trends are acted upon if necessary. The committee meet monthly and discuss the previous months` outcomes.

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.)*