# Oceania Care Company Limited - Wesley Village

## Current Status: 16 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

Wesley Village is part of the Oceania Group. The certification audit was undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board contract. Wesley provides residential hospital, rest home and dementia care for up to 71 residents.

The business and care manager and the clinical leader had extensive experience in aged care and in managing and leading services. Staffing was appropriate to support the needs of the residents requiring hospital and rest home care with staff in the dementia unit trained to provide specialist care.

There was an implemented quality and risk management programme with extensive refurbishment and renovations completed in the hospital/rest home building.

Improvements are required to privacy for residents in bedrooms and labelling of chemicals.

## Audit Summary as at 16 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 |
|  | 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 16 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Organisational Management as at 16 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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 16 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. |

### Safe and Appropriate Environment as at 16 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 16 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 16 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 16 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 and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family and complaints are investigated. The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure residents are informed and have choices related to the care they receive.

An improvement is required to privacy for residents in bedrooms in the hospital/rest home building noting that this is planned as part of the refurbishment programme.

### Organisational Management

Wesley Village has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. Monthly business status reports allow monitoring of service delivery and benchmarking reports are produced that include incidents/accidents and adverse events, infections and complaints. These are used to provide comparisons with other facilities. An internal audit schedule is implemented and there are meetings to ensure that all staff are involved in the quality programme. Resident information is documented in integrated files with sequential and accurate recording of information.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. An orientation/induction programme provides new staff with relevant information for safe work practice and an ongoing training programme is implemented. Staffing levels are adequate and interviews with residents and relatives demonstrate that they have adequate access to staff to support residents when needed. The clinical leader and business and care manager provide operational and clinical leadership and management.

### Continuum of Service Delivery

Entry to the service is facilitated in a timely manner. Adequate information is made available. Residents are kept informed throughout the entry process. There is a comprehensive documented resident agreement, introduction and information brochure for Wesley Village. The service manages all enquiries and declines in an appropriate manner.

Each stage of service provision is provided by a qualified staff member. Care and support needs are implemented in a timely manner. Services are co-ordinated that ensure consistent care was provided.

Appropriate and adequate assessments and person centred care plans are documented and implemented. Results of assessments and care planning evaluations are communicated to the resident/family and the resident`s general practitioner. Additional short term person centre care plans are developed when a need was identified.

Interventions are consistent with best practice standards. Care plans are reviewed six monthly or more often if required.

Adequate planned activities are provided. Planned activities reflect ordinary patterns of life and a wide variety of activities (internal and community focused) are provided. There are two staff, one of whom was a qualified diversional therapist and one assistant activities co-ordinator who facilitate the programme for the secure dementia service and the rest home/hospital.

Timely and appropriate referrals are evident. Transfers are organised and adequate information was communicated throughout the transfer/discharge process.

The provider has a safe medicine management system which was implemented in line with best practice and meets legislative requirements. There is a process for assessing staff medication competency and resident safety in the event of self-administration of medicines. Accurate medication records are maintained and there is evidence of the general practitioners undertaking three monthly medication reviews or more often if required.

The food service is provided by another Oceania Group facility. The menu plans have been reviewed by a dietitian. Residents’ individual food, fluids and nutritional needs are identified and catered for appropriately.

### Safe and Appropriate Environment

All building and plant complies with legislation and a current building warrant of fitness is in place. There is a preventative and reactive maintenance programme including equipment and electrical checks. Activities can occur in any of the lounges and furniture is arranged to ensure residents are able to move freely and safely including space for residents with mobility aids. The dementia unit is a secure unit with a garden/path area for residents. Laundry is outsourced and the managers and staff monitor cleaning. Essential emergency and security systems are in place with regular fire drills are completed. Call bells are in place and these are monitored to ensure that they are functioning at all times.

An improvement is required to ensure that all bottles on the cleaning trolleys are labelled.

### Restraint Minimisation and Safe Practice

There are currently three residents assessed as requiring restraint for safety and two residents assessed as requiring the voluntary use of enablers. The Oceania Group policies and procedures are implemented to ensure the safe use of restraints and enablers. The service actively minimises restraint use.

Staff receive training as part of orientation and this is ongoing. Staff are able to demonstrate their understanding of the restraint minimisation policy and procedures. An enabler is clearly defined. Wesley Village follows the protocol of the organisation inclusive of the restraint approval process, assessment process, evaluation, monitoring and quality review.

### Infection Prevention and Control

There is an appropriate infection prevention and control management system. The infection control programme is implemented and provides reduced risk of infections to staff, residents and visitors. The programme is reviewed annually. The policies and procedures reflect current accepted good practice.

Relevant education is provided for staff and residents. The monthly surveillance programme is suitable for the nature of this aged care residential service. Infections are recorded, analysed and where trends are identified, actions are implemented to reduce infections. The results form part of the monthly clinical indicators and these are benchmarked with other Oceania Group facilities and reported back to all staff.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Oceania Care Company Limited |
| **Certificate name:** | Oceania Care Company Limited - Wesley Village |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Wesley Village | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 16 October 2014 | **End date:** | 17 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:** | 60 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 12 | **Total hours off site** | 5 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 16 | Total audit hours | 40 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 11 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 8 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 16 | Total number of staff (headcount) | 49 | Number of relatives interviewed | 10 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 2 |

## **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 | 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 Tuesday, 4 November 2014

## **Executive Summary of Audit**

**General Overview**

Wesley Village was part of the Oceania Group. The certification audit had been undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board contract. Wesley provided residential hospital, rest home and dementia care for up to 71 residents. Occupancy on the day of the audit was at eight residents requiring rest home level care, 38 requiring hospital level care and 14 in the dementia unit.

The business and care manager and the clinical leader had extensive experience in aged care and in managing and leading services. Staffing was appropriate to support the needs of the residents requiring hospital and rest home care with staff in the dementia unit trained to provide specialist care.

There was an implemented quality and risk management programme with extensive refurbishment and renovations completed in the hospital/rest home building.

Improvements are required to privacy for residents in bedrooms and labelling of chemicals.

**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 and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family and complaints are investigated. The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure residents are informed and have choices related to the care they receive.

An improvement is required to privacy for residents in bedrooms in the hospital/rest home building noting that this is planned as part of the refurbishment programme.

**Outcome 1.2: Organisational Management**

Wesley Village has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. Monthly business status reports allow monitoring of service delivery and benchmarking reports are produced that include incidents/accidents and adverse events, infections and complaints. These are used to provide comparisons with other facilities. An internal audit schedule is implemented and there are meetings to ensure that all staff are involved in the quality programme. Resident information is documented in integrated files with sequential and accurate recording of information.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. An orientation/induction programme provides new staff with relevant information for safe work practice and an ongoing training programme is implemented. Staffing levels are adequate and interviews with residents and relatives demonstrate that they have adequate access to staff to support residents when needed. The clinical leader and business and care manager provide operational and clinical leadership and management.

**Outcome 1.3: Continuum of Service Delivery**

Entry to the service is facilitated in a timely manner. Adequate information is made available. Residents are kept informed throughout the entry process. There is a comprehensive documented resident agreement, introduction and information brochure for Wesley Village. The service manages all enquiries and declines in an appropriate manner.

Each stage of service provision is provided by a qualified staff member. Care and support needs are implemented in a timely manner. Services are co-ordinated that ensure consistent care was provided.

Appropriate and adequate assessments and person centred care plans are documented and implemented. Results of assessments and care planning evaluations are communicated to the resident/family and the resident`s general practitioner. Additional short term person centre care plans are developed when a need was identified.

Interventions are consistent with best practice standards. Care plans are reviewed six monthly or more often if required.

Adequate planned activities are provided. Planned activities reflect ordinary patterns of life and a wide variety of activities (internal and community focused) are provided. There are two staff one of whom was a qualified diversional therapist and one assistant activities co-ordinator who facilitate the programme for the secure dementia service and the rest home/hospital.

Timely and appropriate referrals are evident. Transfers are organised and adequate information was communicated throughout the transfer/discharge process.

The provider has a safe medicine management system which was implemented in line with best practice and meets legislative requirements. There is a process for assessing staff medication competency and resident safety in the event of self-administration of medicines. Accurate medication records are maintained and there is evidence of the general practitioners undertaking three monthly medication reviews or more often if required.

The food service is provided by another Oceania Group facility. The menu plans have been reviewed by a dietitian. Residents’ individual food, fluids and nutritional needs are identified and catered for appropriately.

**Outcome 1.4: Safe and Appropriate Environment**

All building and plant complies with legislation with a current building warrant of fitness is in place. There is a preventative and reactive maintenance programme including equipment and electrical checks. Activities can occur in any of the lounges and furniture is arranged to ensure residents are able to move freely and safely including space for residents with mobility aids. The dementia unit is a secure unit with a garden/path area for residents. Laundry is outsourced and the managers and staff monitor cleaning. Essential emergency and security systems are in place with regular fire drills are completed. Call bells are in place and these are monitored to ensure that they are functioning at all times.

An improvement is required to ensure that all bottles on the cleaning trolleys are labelled.

**Outcome 2: Restraint Minimisation and Safe Practice**

There are currently three residents assessed as requiring restraint use of bedrails or lap belts for safety and two residents assessed as requiring the voluntary use of enablers. The Oceania Group policies and procedures are implemented to ensure the safe use of restraints and enablers. The service actively minimises restraint use.

Staff receive training as part of orientation and this is ongoing. Staff are able to demonstrate their understanding of the restraint minimisation policy and procedures. An enabler is clearly defined. Wesley Village follows the protocol of the organisation inclusive of the restraint approval process, assessment process, evaluation, monitoring and quality review.

**Outcome 3: Infection Prevention and Control**

There is an appropriate infection prevention and control management system. The infection control programme is implemented and provides reduced risk of infections to staff, residents and visitors. The programme is reviewed annually. The policies and procedures reflect current accepted good practice.

Relevant education is provided for staff and residents. The monthly surveillance programme is suitable for the nature of this aged care residential service. Infections are recorded, analysed and where trends are identified, actions are implemented to reduce infections. The results form part of the monthly clinical indicators and these are benchmarked with other Oceania Group facilities and reported back to all staff.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 48 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 2 | 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 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect | Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.3.1 | The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times. | PA Low | Most of the windows have been covered however there are two with frosted glass left that still allow shapes to be seen through the window from the hallway. The business and care manager is aware of these and is continuing to progress with the planned work. | Ensure that residents cannot be seen through windows when attending to personal cares. | 60 |
| 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 | Not all bottles of cleaning chemicals are labelled (four sighted that require labels). | An improvement is required to ensure that all bottles on the cleaning trolleys are labelled. | 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 leader, four of four health care assistants and four of four 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. Staff in the dementia unit (one health care assistant interviewed) confirms that any family member is provided with information around the Code.

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 day 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 six weekly resident 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.

Leaflets around the Code are available at the front entrance of the service. Posters of the Code 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.

Seven residents (one rest home and six hospital) and ten family members (six hospital and four dementia unit) 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:** PA Low

**Evidence:**

The service has a philosophy that promotes dignity and respect and quality of life. This includes a philosophy for the dementia unit that is ‘to provide for the safe and therapeutic care of residents in a home-like comfortable environment that enhances quality of life and minimises risks’. The information pack provided to residents and family entering the dementia unit includes the philosophy.

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people’s beliefs and values with the registered nurses and 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 eight of eight 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 January 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. Four 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 is available four hours a week to assess and review residents. 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 – last provided in December 2013. Staff interviewed are aware of the signs of abuse and neglect and state that there is no evidence of abuse or neglect in the service.

Resident files reviewed (eight of eight including four hospital, three dementia and one rest home) 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.

There are monthly Catholic services with the priest able to visit when required, an Anglican minister who visits fortnightly, Jehovah’s Witness who visit two residents and a Methodist theology graduate who is beginning to visit weekly. There are ministers able to bless rooms when required. Staff have had training around spirituality in February and May 2014.

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

There has been extensive renovation of rooms in the hospital building. This includes putting a transfer onto glass windows so that residents cannot be viewed. Most of the windows have been covered however there are two with frosted glass left that still allow shapes to be seen through the window from the halllway. The business and care manager is aware of these and is continuing to progress with the planned work. An improvement is required to ensure that residents cannot be seen through windows when attending to personal cares.

The District Health Board contract requirements are partially 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:** PA Low

**Evidence:**

There has been extensive renovation of rooms in the hospital building. This includes putting a transfer onto glass windows so that residents cannot be viewed.

**Finding:**

Most of the windows have been covered however there are two with frosted glass left that still allow shapes to be seen through the window from the halllway. The business and care manager is aware of these and is continuing to progress with the planned work.

**Corrective Action:**

Ensure that residents cannot be seen through windows when attending to personal cares.

**Timeframe (days):** 60 *(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 along with guidelines around cultural safety. This includes links to Orakei marae with kaumatua available.

There is one Maori resident living at the facility during this full certification audit. There are staff who identify as Maori and the family members are encouraged to come and visit. The care plan asks around cultural needs. Staff interviewed report specific cultural needs are identified in the residents’ care plans. This was further evidenced in eight of eight resident files selected for review (four hospital, three dementia and one rest home).

Staff are aware of the importance of whanau in the delivery of care for their Maori residents and have had training around the Maori health plan last in October 2014.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The 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 ten family members (six hospital and four dementia unit) and seven residents including six hospital and one resident from the rest home.

One family member of a Cook Island resident states that the family is respected and encouraged to interpret for the family member. The family member states that there are no issues with the service and they value staff for the respect shown to the resident and family.

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 eight of eight staff files reviewed.

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

Interviews with staff including the activities coordinator, four health care assistants, four registered nurses and the clinical leader confirm their understanding of professional boundaries, including the boundaries of the health care assistant’s role and responsibilities

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

Wesley Village 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 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. There is a monthly regional management meeting. Specialised training and related competencies are in place for the registered nursing staff.

Residents and families interviewed expressed a high level of satisfaction with the care delivered.

The general practitioners interviewed (two of two including one who visits the dementia unit only) report 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. The business and care manager attends the ARRC steering group and the NZACA Auckland executive meeting which encourages best and evidence based practice.

Key projects include refurbishment of the facility with this continuing. Rooms have been redesigned so that there is more space in bedrooms and lounge areas.

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

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 15 of 15 completed accident/incident forms.

Family contact is recorded in residents’ files – sighted in eight of eight files reviewed.

Interviews with 10 family members (six hospital and four dementia unit) confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member. The four family members from the dementia unit confirm that they receive information in the welcome pack around care of the resident with dementia and state that staff inform family of changes both in the resident and in the care of people with dementia. Family interviewed confirm that they are invited to attend the six weekly resident meetings.

Interpreter services are available when required from the District Health Board. Staff also interpret on a day to day basis with staff identifying as having a range of ethnicities/language including Fijian, Indian, Phillipino, Tongan, Cook Island, Niuean, Chinese (Mandarin and Cantonese), Cambodian and Nepalese.

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

Staff have had training around communication in March, April and May 2014 and this includes information around open disclosure.

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 and eight files reviewed indicate that forms are signed only by residents deemed competent to complete this.  
  
Eight of eight 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 with two health care assistants who have been with the service for a long period specifically stating that there is more emphasis on residents being as independent as possible. They sight this as being an improvement in care of residents that has occurred over the last three years.  
  
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 responsible for facilitating the six weekly resident meetings held in the hospital area reports that information is regularly provided to the residents regarding their right to access advocacy services through the Health and Disability Advocacy service. Staff training on the role of advocacy services is included in training on The Code of Health and Disability Consumers’ Rights – last provided for staff in March and September 2014.

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 resident’s family/whanau and chosen social networks. Staff including the four 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.

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 shopping, visiting cafes etc.

Residents have performing groups who entertain residents. Residents are included in shopping visits and outings with family members.

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’s forms are available at the entrance.

A complaints register is 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 (only two complaints received in 2014). There is documented evidence of time-frames being met for responding to these complaints.

Seven residents (one rest home and six hospital) and ten family members (six hospital and four dementia unit) all state that they would feel comfortable complaining. One family member states that a complaint had been made and this has been addressed through discussions with the business and care manager. The family members all state that the business and care manager and the clinical leader are very approachable and present during the day and evening which allows concerns to be addressed promptly.

The clinical and quality manager states that there have been no complaints with the Health and Disability Commission since the last audit or with other authorities.

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:**

Wesley Village is part of the Oceania group with the executive management team including the CEO, general manager, operations manager, regional operational managers and clinical and quality managers providing support to the service. Communication between the service and managers takes place on a monthly basis.

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 71 residents (5 rest home beds identified as dual purpose, 46 hospital beds and 20 beds for residents requiring dementia level care). During the audit there are 60 residents living at the facility including eight residents at the rest home level of care, 14 in the dementia unit and 38 requiring hospital level of care.

The business and care manager is responsible for the overall management of the facility and has been in the role for eight years and is a registered nurse with a current annual practicing certificate (APC). The business and care manager has a background of previous facility management with 18 years’ experience in sales for products related to aged care. Professional development relating to the management of an aged care facility exceeds eight hours over the three-month period of time that the business and care manager has been in the role.

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 leader is in charge with support from the clinical and quality manager. The current clinical manager has been employed at the service for the past six years with 10 years’ experience as a district nurse and over 20 years’ experience in aged care.

The clinical and quality manager provides support to a number of Oceania facilities and is a registered nurse, has a certificate in business management, diploma in management and 13 years’ experience in aged care including home care and hospital/rest home/dementia facilities. The clinical and quality manager has been in management roles for eight years and with Oceania for three years.

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:**

Wesley Village uses the Oceania quality and risk management framework that is documented to guide practice. The business plan is documented and reported on through the business status reports with the business and care manager able to describe reporting processes. 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 four health care assistants interviewed.

Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme and improvements identified as being required have a corrective action plan documented and evidence of resolution of issues. There is an internal audit schedule implemented including facility health checks completed by the clinical and quality manager.

There is documented evidence of communication with staff and for all managers through the following meetings: health and safety, infection control, quality, registered nurse and staff meetings as well as in the two monthly restraint meetings. All staff interviewed (four health care assistants, four registered nurses, the clinical leader and the activities coordinator) report they are kept informed of quality improvements and corrective action plans.

There is an annual family and resident satisfaction survey which took place in July 2014. 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 for 2014 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 that expires in March 2015. Health and safety is audited monthly with evidence of corrective actions as these arise.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There has been an outbreak of an infection in August 2014 with the public health department notified (email sighted).

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.

Fifteen incident reports were selected for review. Each incident report had a corresponding note in the progress notes to inform staff of the incident. There was 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:** FA

**Evidence:**

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

Eight staff files were randomly selected for audit. Appointment documentation is 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 the staff files. Police checks are completed with a list of these maintained by the business and care manager.

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARRC) 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 as confirmed by two health care assistants who have been employed in the last 18 months. Annual medication competencies are completed for all registered nursing staff and senior 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.

The organisation has a mandatory education and training programme with sessions held monthly. Staff attendances are documented and there is evidence of good staff attendance. The four health care assistants state that they value the training. Education and training hours exceed eight hours a year.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

The rosters for an occupancy of 46 residents at hospital and rest home level of care is as follows: There are at least two registered nurses in the morning and afternoon with one registered nurse overnight; six health care assistants in the morning, five in the afternoon and three overnight.

There are two health care assistants in the dementia unit at all times and all have completed training around dementia. A registered nurse dedicates some hours each day for the dementia unit and was observed in the afternoon on one day of the audit completing tasks and supporting staff and residents.

The business and care manager (registered nurse) works full-time Monday – Friday and the clinical leader also works full-time.

Residents and families interviewed confirm staffing is adequate to meet the residents’ needs. Family in the dementia unit praised staff for also engaging residents in activities.

There are currently 49 staff including the business and care manager, clinical leader, eight registered nurses, a diversional therapist and one activities staff, six household staff, an administrator and 28 healthcare assistants. Nine health care assistants work in the dementia unit with two others who have also received training in dementia also able to relieve if needed.

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.

Resident files are protected from unauthorised access by being locked away in an office. Informed consent is obtained from residents/family/whanau on admission to display photographs. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.3: Continuum of Service Delivery**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Entry criteria, assessment and entry screening processes are documented and clearly communicated to potential residents, their family/whanau of choice where appropriate, local communities, and referral agencies. The service offers rest home, hospital and dementia care. The service has a pre-entry information brochure which identifies potential residents are required to have appropriate rest home, dementia care and /or hospital needs assessment. Wesley Village is set up with an initial enquiries phone system. Enquiries are transferred to the business and care manager who manages all admissions for this facility. Tours of the facility can be arranged by the business and care manager or the administrator. There are some rooms used to show prospective residents or families.

The service offers rest home, hospital, dementia care and respite care and short term stays depending on bed availability. Referral agencies can be the needs assessment service co-ordination service (NASC), mental health services for older people Auckland City Hospital or other referral services within the Auckland District Health Board (ADHB).

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

When entry to the service has been declined, the potential resident and where appropriate their family/whanau of choice are informed of the reason for this and of other options or alternative services. The pre-entry information brochure stipulates the referral process and the services available being rest home, hospital and secure dementia care.

The clinical leader at interview reports that there would be an appropriate reassessment and that the service provider will assist to find an alternative service provider or refer back to the NASC service in a timely manner. No residents have been declined entry since the total refurbishment and major alterations have been undertaken. The current occupancy is 60 residents of 71 beds being available.

##### **Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)**

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are policies and procedures for the management of continence, challenging behaviour, personal hygiene and grooming, skin integrity, wound care, death and dying, pain and falls prevention to meet agreement requirements. All of these clinical management policies reviewed describe using specific assessment tools and monitoring at appropriate frequencies.

The clinical leader has completed the interRAI training. The four of four registered nurses interviewed report that the registered nurses (8 in total) are responsible for the initial assessments of residents. The comprehensive assessment includes the use of recognised tools used by Oceania Group. There is an initial person centred care plan that is used for the first three weeks until the long term person centre care plan is developed and implemented. Consultation with the resident and family is important and the NASC assessment is the basis of the eight of eight long term person centred care plans reviewed. Goals are documented with appropriate interventions.

Interview with the four of four registered nurses confirms that the initial assessment and initial care plan is developed on the day of admission, the long term person centre care plan is developed within three weeks and reviewed and evaluated at least six monthly.

The eight of eight residents` records reviewed have the initial medical review by the GP recorded within two working days of admission. The residents are reviewed by a general practitioner (GP) at least three monthly, when the resident is assessed as stable. The GP interviewed confirms responsibility for caring for 99% of the residents and this process. The GP has been contracted to this service for four years and visits weekly. The GP states that the communication between the clinical leader and the registered nurses is satisfactory. One other general practitioner interviewed only visits a resident in the dementia unit and states that communication between the nurses is satisfactory. Seven of seven residents interviewed (six hospital and one rest home) report a high level of satisfaction with the medical coverage and feel they are able to access the GP when required.

Each resident has one record which includes the multidisciplinary team input into care, which is documented as part of the care evaluation. The progress notes record interventions each shift. There is a verbal handover between each shift. The registered nurses meet in the staff work room to discuss and receive handover. The handover witnessed provides information which includes updates of all residents, diabetic monitoring, doctor visits, any specialist visits (e.g., gerontology nurse specialist), specimens sent and results. A handover record sheet is used. The four registered nurses interviewed report that there is adequate handover to provide information for the continuity of care and report an excellent team approach to care.

The registered nurses on each shift oversee the secure dementia service twenty four hours a day. Four healthcare assistants interviewed explain that they rotate weekly around the service. The staff who care for the residents in the dementia unit do not cover the rest of the facility. All have completed training in dementia care.

The clinical leader is responsible for managing the register of current annual practising certificates which are reviewed annually. This includes registered nurses, GPs, contracted pharmacists, the physiotherapists, the Oceania Group dietitian and the podiatrist.

The District Health Board contract requirements are met.

Tracer Methodology rest home level care:

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

Tracer Methodology hospital level care:

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

Tracer Methodology secure dementia level of care:

*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 1.3.4: 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 needs, outcomes, and/or goals of residents are identified through the assessment process. The NASC assessment prior to admission is considered as the basis for service delivery planning. The assessments are conducted on admission and at least six monthly when the care plan is reviewed and evaluated. The eight of eight residents` records reviewed (four hospital, three dementia and one rest home) have appropriate assessments to meet the needs of the residents.

There are specific assessment tools for identified specialised needs of the residents, such as wound care, behaviour assessment, restraint/enabler assessment. Where a need is identified, interventions for this are recorded on the person centred care plan. A pain scale is used for pain assessment. The 10 of 10 family/whanau interviewed (six hospital and four dementia) report residents receive appropriate care that meets their needs.

Residents interviewed are very satisfied with the care they receive and that their needs are met.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The eight of eight residents` records reviewed (four hospital, three dementia and one rest home) demonstrate service integration. Each resident has one main care record, which includes input from the multidisciplinary team and the resident/family with consent. There are additional files for each resident that contain archived records (these are accessible in the nurses office in a filing cabinet) The eight of eight person centred care plans reviewed evidence individualised care plans that reflect the resident`s individual needs. The records for the residents reviewed have appropriate care plans and interventions that identify the residents’ needs and care requirements, with person centred specific care plans to respond to an identified need.

The 10 family/whanau, the GP and seven residents interviewed report a high level of satisfaction with the quality of care provided.

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. The eight of eight person centre care plans reviewed (four hospital, three dementia and one rest home) record interventions that are consistent with the residents` assessed needs and desired goals. Observations on the day of the audit indicate residents are receiving care that is consistent with the residents` needs. The seven of seven residents and ten of ten family interviewed report that the service meets the needs of the residents.

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:**

A qualified diversional therapist has been recently employed (two weeks ago). The diversional therapist interviewed is experienced and has had seven years working as a health care assistant. There is an experienced activities assistant who shares this role. Both activities staff work Monday to Friday and split the weekends to ensure activities are provided over this time. The two activities plans reviewed are flexible and are developed to meet the needs, interests, skills, strengths and capabilities of the residents. The dementia unit activities cover the twenty four hour period. The plans sighted cover cognitive, physical and social needs. The activities programme includes community and seasonal events (such as religious celebrations, sporting events, mother`s day and other special days).

The diversional therapist reports activities plans are individualised to the resident`s needs after completing an activities assessment. The activities plans are developed in conjunction with the residents and where appropriate family input. Where possible resident`s independence is encouraged to maintain links with family and community groups. Six weekly resident meetings are held and minutes are recorded and were reviewed.

A recreation attendance record is completed but activities are voluntary for residents to attend. Two activities sessions are in progress and observed one in the dementia unit and one in the activities room allocated for this purpose. The hospital residents interviewed (seven of seven) report they enjoy activities and the one on one activities are also provided if they are unable to attend the group session. The dementia unit was homely and the staff were observed interacting and performing a variety of activities in the dementia unit lounge.

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:**

The eight of eight person centred care plans evidence evaluations are recorded at least six monthly by the registered nurses, with input from the GP, the resident, the family and the activities coordinator and the pharmacist. The documented care plan evaluations indicate the resident`s progress in meeting goals, and the person centre care plans are updated to reflect progress towards meeting goals.

Where progress is different from expected the registered nurses either updates the long term person centred care plan or use a short term person centred care plan for temporary changes. The eight of eight residents` records reviewed indicate they are updated to reflect changing needs of the resident. The seven of seven residents and ten of ten family/whanau interviewed report involvement in the evaluation process and are satisfied with the care provided.

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:**

The clinical leader or the RN on duty or the GP arrange for any referral to specialist medical services when it is necessary. The GP and the clinical leader interviewed report that referral services respond promptly on receipt of the referral sent. Records of the process are maintained as confirmed in the eight of eight residents` records reviewed, which included referrals and consultations with the general medical, surgical, mental health, orthopaedic, psychiatrist, radiology, gerontology nurse specialist, eye clinics and the Oceania Group dietitian. The GP interviewed report that appropriate referral to other health and disability services are well managed and report that this is a strength of this service.

The three tracer residents reviewed using tracer methodology have had referrals sent to other health professional to seek appropriate opinions and/or treatments to meet the needs of the individual residents.

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:**

Risks identified prior to a planned discharge and transfer are clearly documented and form the basis of planning the required transfer. When a resident is transferred to secondary or tertiary level care the service uses the DHB inter-hospital transfer form and yellow envelope system. The transfer form provides a summary that covers all aspects of care provision and intervention requirements, including any know risks or concerns.

A copy of the resident`s individual risk profile, and individual record front information page, medication profile and any know allergies and a summary of medical notes and a copy of any known advanced directives also accompany the resident. There is evidence of open communication between the service and family/whanau related to all aspects of care, including exit, discharge and transfer. If there is any specific requests or concerns that the family/whanau or resident want discussed, these are noted on the transfer form.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The medication management policies sighted comply with legislation and guidelines reviewed. The system used is well facilitated and managed for this residential care facility. The clinical leader explains the process and one registered nurse discusses the medication system on the tour of the facility. Medicines are received from the contracted pharmacy in a medication sachet delivery system. The signing sheets record the sachets are checked for accuracy by two registered nurses against the residents’ medication records. A medication reconciliation process occurs with new admissions and when the resident has been to a specialist or hospital admission. The pharmacist conducts six monthly reconciliations, six month stocktakes and audit of the medication management system.

Medicines are stored in locked medication trolleys and in the locked treatment rooms in the rest home/hospital and the secure dementia unit. Stock rotation is checked regularly that are not packed into the sachets. The controlled drugs are stored in a locked safe, two staff sign the register at each administration and a weekly stock count is undertaken.

Standing orders are reviewed annually and this was completed 25 July 2014 by the GP. The GP interviewed verifies this occurred and the GP is satisfied with the medication system and that staff report immediately any errors in medication administration or changes in residents related to medication they are prescribed.

Sixteen medication records were randomly selected and reviewed (six hospital, five rest home and five dementia unit). There is clear evidence of the three monthly medication reviews being performed by the GPs. All prescribed medication sighted contains the date, medicine name, dose, time of administration with any allergies and/or sensitivities highlighted in red ink. All medicine charts reviewed have each medicine individually prescribed and signed off by the GP. There is no evidence of residents’ self- medicating medications though a process is documented should this be required. The GP interviewed understands that the resident is to be deemed competent to manage their own medications and there is an appropriate form which is completed if needed.

In the front of the medication records folders is a list of specimen signatures for staff, approved abbreviations and the food supplement list which is prescribed by the GP or the Oceania dietitian by special authority. Also evident is the list of staff competent to administer medication which includes the 10 of 10 registered nurses and eight health care assistants who have completed annual medication competencies. Preparing nebulisers and oxygen administration can be managed by the same list of staff when and if required for a resident. The four registered nurses interviewed report the medication system is well managed and is overseen by the clinical leader.

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 menu review is based on the dietitian NZ audit tool for residents living in long term care. The Oceania dietitian is responsible for reviewing or making any changes to the menu plan. The registered nurses at the time of admission perform a nutritional profile for each individual resident and this information is shared with the chef responsible for meal preparation to ensure all needs, wants, dislikes and special diets are catered for all residents. For example, the service provides diabetic and texture modified diets to meet specific residents` needs.

The meal service is not prepared on site at Wesley Village. The meals are prepared and delivered to this facility from another facility owned by the Oceania Group. Serveries are available in the dementia unit and in the rest home/hospital. There is one main entry point server for the food on arrival and then this is transported in bain maries to the serveries provided.

There are dining room facilities in the dementia unit and in the rest home/hospital. A kitchen assistant who is responsible for this service was available for interview. This person has to test the food temperatures on arrival and at time of serving the meals in the serveries. The kitchen staff member collects and does the dishes after breakfast lunch and dinner. Special functions are also catered for as needed by the chef. Fridge temperatures in the serveries are monitored and the temperatures are documented on the check sheets sighted. Any variances are reported to management if there is any variation from normal.

Staff are observed wearing personal protective equipment such as gloves, hats and aprons during meal service or lunch and dinner. The breakfast is prepared by the health care assistants who serve in the dining rooms or go to the individual rooms to serve up breakfast requirements for individual residents. Food hygiene courses are provided by the organisation for all staff.

Surveys and feedback from the residents’ meetings held monthly are reported back to staff. Residents and family are satisfied with the meals provided.

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. 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 facility (expiry date 4 October 2015). There have been no building modifications since the last audit, however there has been significant redesign of bedrooms and communal spaces. The refurbishment is continuing.   
There is a planned maintenance schedule implemented and any receipts of work completed are retained with the business and care manager working with the Methodist Mission who owns the property to ensure that maintenance is completed.

The following equipment is available, pressure relieving mattresses, shower chairs, sitting scales, hoists and sensor alarm mats. There is a test and tag programme two yearly and this is up to date (last completed in October 2104) with BV Medical checking medical equipment annually (last completed in September 2014). Testing and tagging of electrical equipment is also completed for new residents when admitted. Interviews with four of four health care assistants, four registered nurses and the clinical leader confirms that 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 including a secure outdoor environment for residents in the dementia unit. The dementia unit has sufficient space to allow maximum freedom of movement for residents likely to wander including an outdoor 'circuit'.

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. A number of bedrooms in the hospital/rest home building now have ensuites, some of which are shared between two bedrooms. All have locks or other methods of noting if the room is engaged that ensures privacy for residents when in use.

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

Seven residents (one rest home and six hospital) and ten family members (six hospital and four dementia unit) interviewed report that there are sufficient toilets and showers with a number of rooms having their own ensuite.

The dementia unit has toilet and shower facilities that meet the needs of residents. Staff supporting residents to access toilets and showers in the unit do this with respect and encouragement. The toilet and shower facilities in the unit are separate to those provided for other residents.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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.

Equipment is sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff and the resident. Residents requiring use of a hoist were sighted on the day with staff supporting them in their rooms with sufficient space for all. The four health care assistants confirm that there are always two staff supporting any resident using a hoist.

Rooms can be personalized with furnishings, photos and other personal adornments including rooms in the dementia unit.

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

Each resident in the dementia unit has their own room.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

The service has lounge/dining areas and these are large with appropriate floor coverings in each part e.g. carpet in the lounge area of the room. All areas are easily accessed by residents and staff. 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.   
  
Residents state that they like the large dining/lounge areas as they are easy to negotiate especially for residents using mobility aids including wheelchairs. In the hospital area, there is a room for activities that is well used during the audit.   
  
Residents are able to access areas for privacy if required including rooms available for residents in the dementia unit (a small and large lounge).   
  
Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.   
A specific area for the hairdresser is located in the hospital with residents from the dementia unit also able to access this.  
  
The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Laundry is subcontracted to a service and is independent to Wesley Village. Seven residents (one rest home and six hospital) and 10 family members (six hospital and four dementia unit) state that the laundry is well managed and they get back their clothes.

Cleaning is monitored through the internal audit process with no issues identified in audits last completed in 2014. The business and care manager also organises to have the carpets cleaned six to eight weekly.

Chemicals and cleaning cupboards are locked away when not in use.

The cleaners were observed to have the trolley in the room with them when cleaning. Ecolab products are used with training around use of products provided in 2014. Most bottles of chemicals are labelled. An improvement is required to ensure that all bottles on the cleaning trolleys are labelled.

The District Health Board contract requirements are not fully 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:**

The cleaners were observed to have the trolley in the room with them when cleaning. Ecolab products are used with training around use of products provided in 2014. Most bottles of chemicals are labelled.

**Finding:**

Not all bottles of cleaning chemicals are labelled (four sighted that require labels).

**Corrective Action:**

An improvement is required to ensure that all bottles on the cleaning trolleys are labelled.

**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 24 July 2001. 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 these up to date 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, review of staff files and confirmed by the business and care manager.

All required fire equipment is 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 water (a large water tank which is gravity fed), blankets, extra linen including towels and face cloths and a gas BBQ. A backup generator ensures that heating of the boiler and emergency lighting would continue. The service has access to food in the event of an emergency from other facilities noting that the service sub-contracts food services.

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 audits are routinely completed with CDI (external provider) confirming client satisfaction with the system. One bell was not able to be utilised on the first day of the audit (flat battery) and the staff from CDI replaced this on the morning of the second day of the audit. One health care assistant confirmed that they were keeping ‘an extra eye’ on the toilet to ensure that residents and other using this were safe at all times.

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.

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 boiler to heat radiators and this is checked by an external company three monthly (records of checks sighted).

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:**

The restraint minimisation policy contains clear definitions of restraint and enablers that meet the requirements of this standard. Policy and procedures are in place to ensure any restraint is actively minimised. Policy identifies enablers are voluntarily used by a resident following appropriate assessment. When an enabler is used, consent will be sought and documented.

During discussion with the clinical leader, four registered nurses and four health care assistants they clearly demonstrate knowledge and understanding of the definition of an enabler and the process required to be followed should restraint be used. Staff education relates to restraint minimisation including de-escalation techniques and management of challenging behaviour. This training occurred on 12 March 2014 with good staff attendance recorded. Education is part of the orientation process and is a compulsory topic annually.

The clinical leader is the restraint co-ordinator. There are three residents using a form of restraint and two residents using an enabler and this was evidenced in the restraint register maintained by the clinical leader.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Approved restraints identified in policy are bedrails and lap belts. An email sighted received by the clinical leader from the senior clinical and quality manager for Oceania on the 27 August 2014 stated that staff were being informed that the restraint policy now includes use of chair briefs (as a safe and discrete form of restraint) which has been trialled. The restraint co-ordinator is the clinical leader and there is a job description for this role.

The approval group for this service consists of the clinical leader, the GP and two registered nurses. The restraint team meetings are held three monthly but have recently been changed by Oceania Group policy to be held two monthly. Policy identifies the role for the restraint approval group. The approval for each restraint is reviewed six monthly or more often if required. A flow chart for restraint management is available to guide staff. All restraint policies and procedures were reviewed March 2013 and next due March 2015. Terms of reference are acknowledged and clearly documented on the policy to guide staff. All approval forms sighted have been signed and dated appropriately.

Approved restraint/enablers are documented in the restraint register. The service uses a separate restraint plan which clearly identifies any alternatives to restraint/enabler use. The person centred care plans are used by staff to ensure safe service delivery for each resident. Interviews with four registered nurses and four healthcare assistants confirm their understanding and use of the management documented in the care plan. Education is available at orientation and is ongoing and covers alternatives for restraint use which is promoted. Education was provided 12 March 2014 and 5 August 2014.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Comprehensive assessments of residents are undertaken in relation to use of a restraint. A copy of the restraint assessment authorisation and plan is available for each resident in their individual record reviewed. The restraint approval forms are signed and dated of by the GP. Minimal residents three of 60 are using a restraint. Safety is promoted as verified by staff interviewed four health care assistants and four registered nurses.

Pre-restraint/enabler assessment includes all requirements of this criterion as sighted in the restraint minimisation documentation. All assessments are undertaken by the registered nurses or the clinical leader. The respective care plan is then developed in partnership with the resident and/or family/whanau or other representative as confirmed by one family member of 10 interviewed whose family member is using a bedrail as a restraint. Assessments include known risk factors, such as susceptibility to skin tears, and cultural requirements are considered by staff. This is confirmed in the five of five resident records for the three residents using restraint and two residents using an enabler.

The District Health Board contract requirement is met.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

Wesley Village ensures all procedures in place are continually monitored by the restraint approval group. Policy is reviewed two yearly. All restraint is approved prior to use following the appropriate assessment processes being completed and reviewed by the approval group. Monitoring is determined by the identified risk of restraint/enabler in use. All restraint/enablers used for safety purposes only. The restraint register sighted identifies all restraint/enabler use. Staff education is appropriate for the type of restraint used. Restraint is seen as a serious intervention which required clinical rationale and is use as a last resort only. The four registered nurses and four health care assistants interviewed have good understanding of the principles of restraint for safety and maintaining restraint independence as applicable. Training is available and has been provided 12 March 2014 and 5 August 2014. The clinical leader maintains the restraint register.

Restraint is monitored and reviewed monthly at the management and staff meetings and two monthly meetings now held for the restraint approval meetings. Bench marking occurs with all Oceania Group facilities and comparative information is displayed quarterly in the staff room and in the dementia unit.

Individual monitoring requirements are undertaken according to identified risks with a maximum of two hourly recordings being undertaken when restraint/enablers in use. The commencement and cease times are accurately recorded for restraint use.

The District Health Board contract requirement is met.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The service undertakes an evaluation of all restraint use a minimum of six monthly. Family/whanau or a nominated representative is involved in all evaluation processes, if consented by the resident, each six months. Consultation sought is documented. The restraint/enabler evaluation forms records the evaluation date, type restraint used, reason for the use of the restraint (safety, behavioural or other reason), the desired outcome/goal is recorded and any changes the resident may have experienced during the restraint use. Any incidents reported during the use of the restraint commencing and what impact the restraint has had on the resident/family/whanau is noted. Safe practice is recognised in the resident records reviewed across all services.

The individual resident`s person centred care plan is updated if any changes have occurred. The details of the staff member completing the evaluations is recorded and the GP involved signs and dates the evaluation form and this is clearly observed in the records reviewed.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service is able to demonstrate via the documentation sighted that six monthly monitoring and annual quality reviews are conducted relate to the use of restraint/enablers. Quality review findings and recommendations are used to improve service provision and resident safety. Restraint meeting minutes are sighted for 7 April 2014, 1 July 2014 and 9 September 2014. There are currently three residents of 60 using a restraint and two residents using an enabler for safety purposes. Training continues to be provided as per the training records reviewed. This is also evident in the orientation checklist for new staff and a workbook is completed. Annual education is mandatory. Two sessions have been held to ensure all staff complete the education annually.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

There is a comprehensive infection control manual which contains policies that meet the requirements of the standards. The clinical leader is the infection control co-ordinator. There is a job description for this role. There are clear guidelines for accountability and responsibility for the role. The infection control co-ordinator monitors for infections, uses standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is a standing agenda item in the quality risk meeting and staff meetings held monthly. The surveillance results are communicated to staff in the minutes of the quality reports, with monthly results and graphs displayed on the staff notice board. If there is any infectious outbreak this is reported to staff, management and where required, to the ADHB and public health departments. There has been one outbreak since the last audit. This was between 30 August 2014 and the 12 September 2014. Eleven cases (two in the dementia unit and nine in the hospital/rest home) and protocol was followed. The outbreak register is available and was reviewed. The public health protection officer was notified and an email confirmation was verified. The register was sent to public health for review of processes followed.

The infection control programme includes, monthly infection control reports, infection log and notification of infection processes, policies and procedures and infection prevention and control education. The infection control programme is reviewed annually.

A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at entrances. Sanitising had gel is available throughout the facility and there is adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are isolated if required and as appropriate. Staff policy states not to come to work when suffering from infectious diseases. Staff interviewed are able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing.

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 co-ordinator, the clinical leader facilitates and implements the infection control programme. The infection control team consists of the infection control co-ordinator/ the clinical leader, one registered nurse, one household staff member and two health care assistants. The infection prevention and control team is incorporated into the monthly risk management meeting. External specialist advice on infection prevention and control issues is available, if and when required, from the ADHB infection control nurse specialist, the diagnostic service, GP, pharmacist and the Ministry of Health as required. The organisation is a member of Bug Control an advisory service on infection prevention and control specifically for the aged care sector. The infection control team has the authority to increase staffing levels in case of an outbreak to provide safe care.

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:**

The policies and procedures at the time of the audit cover all requirements identified in the Health and Disability Services Infection Control Standards. The clinical leader advises that the Oceania policies and procedures are reviewed at head office and signed off by senior management. Reviewed 2013 and next for review 2015. The existing policies and procedures are referenced to best practice and evidence based research. Observations at the onsite audit identify the implementation of infection prevention and control procedures. Staff (care staff, cleaning, household and food service) 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 is part of the orientation and presented as a regular in-service education programme. The clinical leader is responsible for infection control education and maintains an education log for this facility. The log is completed monthly. Infection control is recorded as being provided on 6 January 2014 and infection control compliance was recorded as May 2014. The infection control team maintain their knowledge and the ICC attends infection control sessions at the ADHB. The facility is a member of Bug Control and a representative visits annually and provides in-service education.

The ICC reports at interview that there is informal education with residents especially in regard to hand washing techniques, importance of fluid intake and education in relation to wound-care management.

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:**

Infection control data is collected on urinary tract infections, chest infections, wound infections, eye and ear infections and multi-resistant organisms. The surveillance data is gathered for the rest home, hospital and dementia unit level care residents. The monthly report is of collected data is provided to the ICC from all areas of service delivery to the infection control co-ordinator. This is presented at the quality meeting along with quality, restraint, and health and safety. Feed-back is provided to all staff. The surveillance data is also displayed on the staff notice board. The surveillance data is collected is based on infections per 1000 occupied days. The surveillance system is appropriate for the size and complexity of services provided at Wesley Village.

All care staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken. The data sighted for 2014 is less than for last year. The alterations to the facility and new resources being made available had an impact on the figures this year as the facility is very new. The dementia unit still has a significant increase in urinary tract infections. Increased informal staff education at the staff meeting and handovers on the importance of hand hygiene, standard precautions and encouragement of fluids was conducted.

##### **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.)*