

Oceania Care Company Limited - Victoria Place Rest Home & Hospital

Current Status: 10 September 2014

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

General overview

Victoria Place Rest Home, Hospital and Dementia Care was part of the Oceania Group. This surveillance audit had been undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Victoria Place Rest Home, Hospital and Dementia Care provided residential hospital, dementia care and rest home level care for up to 51 residents with 46 residents occupying the service on the day of the audit.

There was a business and care manager who had been in the role since June 2014. There was a clinical leader (registered nurse) who provided clinical oversight and the service was also supported by the operations and clinical and quality managers. Staffing was appropriate to support the needs of residents requiring hospital, dementia and rest home care noting that there had been an increase in staffing since the new manager has been in place.

There was a quality and risk management programme implemented with implementation of a programme that included monitoring of complaints, restraint, health and safety, an internal audit programme and key indicators.

Two improvements required at the certification audit have been completed around recording of trends on the national data base and care plans to reflect current needs.

Improvements are required to the following: documentation of complaints, the activities programme and documentation of general practitioner registration details in medication records.

Audit Summary as at 10 September 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained

Indicator	Description	Definition
	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 10 September 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Organisational Management as at 10 September 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 10 September 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 10 September 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 10 September 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 10 September 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	Oceania Care Company Limited
Certificate name:	Oceania Care Company Limited - Victoria Place Rest Home & Hospital
Designated Auditing Agency:	Health Audit (NZ) Limited
Types of audit:	Surveillance Audit
Premises audited:	Victoria Place Rest Home/Hospital and Dementia Care
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 September 2014 End date: 10 September 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	46
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Audit Team

Lead Auditor	XXXXXXX	Hours on site	8	Hours off site	6
Other Auditors	XXXXXXX	Total hours on site	8	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXX			Hours	2

Sample Totals

Total audit hours on site	16	Total audit hours off site	12	Total audit hours	28
Number of residents interviewed	7	Number of staff interviewed	7	Number of managers interviewed	2
Number of residents' records reviewed	7	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	14	Total number of staff (headcount)	44	Number of relatives interviewed	6
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Thursday, 18 September 2014

Executive Summary of Audit

General Overview

Victoria Place Rest Home, Hospital and Dementia Care was part of the Oceania Group. This surveillance audit had been undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Victoria Place Rest Home, Hospital and Dementia Care provided residential hospital, dementia care and rest home level care for up to 51 residents with 46 residents occupying the service on the day of the audit.

There was a business and care manager who had been in the role since June 2014. There was a clinical leader (registered nurse) who provided clinical oversight and the service was also supported by the operations and clinical and quality managers. Staffing was appropriate to support the needs of residents requiring hospital, dementia and rest home care noting that there had been an increase in staffing since the new manager has been in place.

There was a quality and risk management programme implemented with implementation of a programme that included monitoring of complaints, restraint, health and safety, an internal audit programme and key indicators.

Two improvements required at the certification audit have been completed around recording of trends on the national data base and care plans to reflect current needs.

Improvements are required to the following: documentation of complaints, the activities programme and documentation of general practitioner registration details in medication records.

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. 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. Staff communicate with residents and family members following any incident.

An improvement is required to documentation of verbal complaints around basic cares provided to residents with evidence of follow up and resolution of issues.

Outcome 1.2: Organisational Management

The service 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. Benchmarking reports are produced that include incidents/accidents, infections and complaints with an implemented internal audit programme. Corrective action plans have been put in place with the appointment of the new business and care manager.

Staffing levels are adequate and interviews with residents and relatives demonstrate that they have adequate access to staff to support residents when needed. Staff in the dementia unit are trained in dementia care. While the clinical leader and business and care manager have only been appointed to the service within the last two months, there has been significant improvement made to the service around staffing, quality improvement and to the clinical care of residents.

Improvements required at the certification audit have been completed around recording of trends on the national data base.

Outcome 1.3: Continuum of Service Delivery

The resident records in the rest home, hospital and dementia services evidence the provider has implemented systems to assess, plan and evaluate the care needs of the residents. Care planning demonstrates residents and their family participate in care planning processes. The residents` identified needs, outcomes and/or goals are identified and reviewed in the timeframes required or more frequently if required. One area of required improvement in the previous audit is now fully attained. Three records were reviewed using tracer methodology. The service is co-ordinated to promote team work and continuity of care.

Activities are co-ordinated and implemented in a planned and organised manner for the rest home and hospital level residents. The activities programme reviewed supports the interests, needs and strengths of residents. Residents and family interviewed confirm their satisfaction with the programme. However, there is an area of required improvement in relation to the activities programme for the dementia level care residents.

The service has an appropriate medicine management system which is developed and implemented in line with best practice and legislative requirements. All medications are prescribed, stored and administered safely. There is a process for assessing staff competency and in the event of self-administration. Adverse events, and/or errors are monitored. The general practitioners review all medications in the timeframes required and communicate with the registered nurses and contracted pharmacy effectively when required. There is one required area of improvement identified for medication management in relation to information needing to be documented.

Food services policies and procedures are reviewed and there is evidence of dietitian review and input of the winter and summer menus. Resident`s individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection evidences compliance with current legislation and guidelines utilised. Residents and family/whanau interviewed report satisfaction with the food service.

Outcome 1.4: Safe and Appropriate Environment

There is a current building warrant of fitness in place. There is a preventative and reactive maintenance programme including equipment and electrical checks. The facility is appropriate to the needs of residents with a secure unit for residents identified as requiring this. The dementia unit has been refurbished with new flooring and colour to walls added.

Outcome 2: Restraint Minimisation and Safe Practice

The use of restraint is actively minimised. Staff receive education on restraint use, enablers, and the management of challenging behaviours. There are six residents assessed as requiring the use of an enabler at the time of audit. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain their independence and/or for safety.

Outcome 3: Infection Prevention and Control

The infection prevention and control programme aims to prevent the spread of infection and reduce the risks to residents, staff and visitors. Policies and procedures are aligned with currently accepted good practice. There is a surveillance programme which is appropriate for the size and nature of the services provided. Monthly surveillance data and audits is recorded, collated and reported to head office. Analysis and evaluation of data is used to develop any corrective actions required, which are monitored by the infection control co-ordinator in a timely manner.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	2	1	0	0
Criteria	0	39	0	2	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	59

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Moderate			
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Moderate	Three of the six family members when asked identified some aspects of care which required improving. These included making sure that they were kept informed if cares were not able to be completed (e.g. if the resident was not shaved as they could not tell if staff had forgotten or if their family member had refused care, concern that their family member had washes overnight when necessary, not sure if their family member had been turned two hourly as planned). All three family state that they had raised the care issues	Ensure that all verbal complaints are documented on the complaints register with follow up to ensure that cares are being completed as planned.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				with staff however these are not documented on the complaints register and the current manager who has been in the role since June 2014 has not heard of the complaints before.		
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low			
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	There is no diversional therapist or occupational therapist to provide oversight for the dementia unit activity programme and there is no evidence of a resident 24 hour activity programme being documented or implemented for these residents.	Provide oversight of the activities programme by a qualified person and to ensure that there is an individual resident 24 hour activity programme documented and implemented.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.6	Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	The name of the general practitioner, the contact details and the registration numbers are not consistently documented on the rest home level residents' medication records reviewed.	Ensure that the name of the general practitioner, contact details and the registrations number is documented on the medication records for the rest home residents.	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 1.1.9: 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 10 of 10 completed accident/incident forms and in the resident files.

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

Interviews with six family members (two hospital, two dementia unit and two rest home) confirm that five of the six are kept informed (one from the hospital states that at times the whole family is not kept up to date and the family member identified as the enduring power of attorney is not informed). Family also confirm that they are invited at least six monthly to the care planning meetings for their family member.

Family interviewed confirm that they are invited to attend the resident meetings monthly and are kept informed through the monthly newsletter which has been produced by the business and care manager.

Interpreter services are available when required from the District Health Board. There is one resident who does not speak English well and there are a mix of staff who can speak the resident's language and family who come in two or more times a week. The family have also left language notes for reference for staff and one health care assistant specifically asked states that staff use these to support the resident. The business and care manager also states that the staff are trying to access books in the resident's language.

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

Staff have had training around communication in 2014.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The organisation's complaints policy and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes periods for responding to a complaint. Complaint's forms are available at the entrance of the rest home and hospital. There is also a 'mail' box and anyone can put a note in the box with follow up according to the complaints policy.

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

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

Seven of seven residents (three hospital and four rest home) and six family members (two hospital, two dementia unit and two rest home) state that they would feel comfortable complaining. One family member states that a complaint had been made and this has been addressed through the care plan review. Three of the family members when asked, identified some aspects of care which required improving noting that overall the family members state that they are satisfied with the service provided. These include making sure that they were kept informed if cares were not able to be completed (for example, if the resident was not shaved as they could not tell if staff had forgotten or if their family member had refused care, concern that their family member had washes overnight when necessary, not sure if their family member had been turned two hourly as planned, unsure if a resident has been supported to eat a meal as when they come in the meal is still waiting beside the resident). All three family state that they had raised the care issues with staff however, these are not documented on the complaints register and the current manager who has been in the role since June 2014 has not heard of the complaints before. One family member identified that they were dissatisfied with their family members care in the August 2014 satisfaction survey, however all others identified that they were satisfied or very satisfied. The results of the 2014 satisfaction survey have yet to be addressed although the survey has been collated.

There is one complaint from the Health and Disability Commission dated May 2014. The business and care manager has responded to the complaint and the service is waiting to hear back from the Health and Disability Commissioner.

The District Health Board contract requirements are partially met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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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: PA Moderate

Evidence:

There is a complaints policy in place. Seven of seven residents (three hospital and four rest home) and six family members (two hospital, two dementia unit and two rest home) state that they would feel comfortable complaining.

Finding:

Three of the six family members when asked identified some aspects of care which required improving. These included making sure that they were kept informed if cares were not able to be completed (e.g. if the resident was not shaved as they could not tell if staff had forgotten or if their family member had refused care, concern that their family member had washes overnight when necessary, not sure if their family member had been turned two hourly as planned). All three family state that they had raised the care issues with staff however these are not documented on the complaints register and the current manager who has been in the role since June 2014 has not heard of the complaints before.

Corrective Action:

Ensure that all verbal complaints are documented on the complaints register with follow up to ensure that cares are being completed as planned.

Timeframe (days): 90 (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:

Victoria Place Rest Home, Hospital and Dementia Care is part of the Oceania group with the executive management team including the chief executive officer, general manager, operations manager, regional operational managers and clinical and quality managers providing support to the service. Communication between the 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 51 residents requiring hospital, dementia or rest home level of care. During the audit there are 46 residents living at the facility including 16 residents at rest home level of care (total of 16 available beds overall with four identified as being dual purpose), 12 requiring dementia level care (total of 13 available beds overall) and 18 residents at hospital level of care (total of 22 available beds overall).

The business and care manager is responsible for the overall management of the facility. The business and care manager has been in the role since June 2014 and an email confirms that HealthCERT has been notified of the appointment. The business and care manager has a background of over 20 years in aged care with a recent role as clinical manager at another Oceania facility and is supported by the clinical leader who has been in the service for one month.

The business and care manager is supported by the clinical and quality manager, and operations manager.

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 1.2.3: 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:**

Victoria Place Rest Home, Hospital and Dementia Care uses the Oceania quality and risk management framework that is documented to guide practice.

The business plan is documented and reported on through the business status reports. This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products.

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

All staff interviewed including three of three health care assistants, the activities coordinator, the maintenance staff, the clinical leader, the cook and a registered nurse report they are kept informed of quality improvements

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. 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 – expires 31 March 2015.

There is a Community Connect newsletter from the organisation.

There are expected to be annual resident/family satisfaction surveys. A collated report from the August 2014 survey indicates that residents and family are 62.5% very satisfied, 25% satisfied overall and 12.5% no response. The business and care manager states that the results will be presented at the next quality and risk meeting minute in September 2014. Only one resident identified areas of improvement (refer 1.1.13).

Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme noting that improvements identified as being required have a corrective action plan documented and evidence of resolution of issues documented in meeting minutes particularly in the quality and risk meeting minutes and other meeting minutes when these are documented. The previous managers did not complete corrective action plans as a result of internal audits routinely however, there is sufficient evidence since June 2014 that these are now being documented and the business and care manager is committed to continuing to document these with evidence of resolution.

There are meetings held across the service including monthly quality and risk meetings, health and safety, resident/family, infection control, registered nurse (as necessary) and staff meetings. There are two monthly restraint meetings.

The previous improvement required around recording of trends on the national data base has been met.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

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

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

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

Attainment and Risk: FA**Evidence:**

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

Attainment and Risk: FA

Evidence:

The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are no times since the last audit when authorities have had to be notified apart from notifying HealthCERT of the change in the business and care manager.

There have been no outbreaks since the last audit.

The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff and the business and care manager. The service has recognised the need to improve the quality of service provided through robust monitoring and provision of care and is now implementing systems to ensure that this occurs.

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.

Ten incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event (refer 1.1.13).

Information gathered is regularly shared at the monthly quality and risk meeting and staff meetings with the business and care manager documenting incidents which are then graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)**

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

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

Attainment and Risk: FA**Evidence:**

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

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

Criminal vetting is completed – sighted in employee files reviewed.

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract. Health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and health care assistants who administer medicines to residents. Other competencies are completed including hoist, oxygen use, hand washing, wound management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower. As these have not been well completed in the past, there has been a focus on ensuring that all staff have completed competencies in August 2014 – records sighted.

The three health care assistants state that they value the training. Education and training hours exceed eight hours a year. All staff have completed core training around all aspects of the quality programme since the new business and care manager has been appointed.

Mandatory training is identified on an Oceania wide training schedule. There are folders of attendance records and training with a spreadsheet maintained by the business and care manager with all training included. Staff training records are now maintained in a format that enables verification of completion of identified mandatory training by relevant staff.

The business and care manager states that all kitchen staff have a record of completing food service and hygiene training.

Seven files reviewed include all relevant documentation.

All health care assistants working in the dementia unit have completed dementia training.

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 are as follows:

There is a registered nurse on at all times with the clinical leader on in the morning weekdays. The business and care manager proposes to increase the registered nurse numbers by one extra three days a week.

The business and care manager (registered nurse) and the clinical leader (registered nurse) work full-time Monday – Friday and share the on call in the meantime.

There are staff rostered to provide support to each unit i.e. dementia unit (two health care assistants until 2100 and then one overnight), rest home (one health care assistant at all times with a short shift in the morning and afternoon) and hospital (four health care assistant in morning including three full shifts, three in the afternoon with two on full shifts and two full shifts overnight).

There are a number of new staff appointed as staffing prior to the current business and care manager had been lower than the staffing matrix documented in the policy.

Residents interviewed confirm staffing is adequate to meet the residents' needs and two of the five family members interviewed confirm that staffing is adequate. Three family members state that there is insufficient staff to support their family member noting that two of the three residents require full cares. When asked further, all state that care is adequate but that they are not sure that cares are occurring consistently with some examples given of when cares have not occurred (refer 1.1.13) .

Three health care assistants when asked state that there are not enough staff however when asked if they can complete cares required on all shifts in all areas, all state that they can but at times they are busy.

There is a review of the roster currently in place to ensure that there are now sufficient staff on each shift given the recent changes and the adjustment of hours for staff to cover times when there are high care needs required.

There are currently 44 staff including the business and care manager, clinical leader, one enrolled nurse, five registered nurses, one activities coordinator, one laundry assistant, three cleaners (seven days a week), one cook and two kitchen assistants and 29 health care assistants.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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 1.3.3: 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:

Service delivery documentation is overseen by the clinical leader and managed by the five team leaders who are registered nurses. The resident records are reviewed at regular intervals to ensure documentation is completed within required timeframes. Seven of seven resident records (two rest home, three hospital and two dementia) reviewed evidence an initial assessments are completed for all residents as part of the admission procedure. The initial care plans is developed and within three weeks the long term patient centred care plan (PCCP) is developed and implemented.

Additional recognised clinical assessment tools used include falls, pressure area, incontinence, pain and challenging behaviour. The newly appointed clinical leader (one month in this position) has completed the InterRAI training. The long term PCCP template is personalised individually for each resident to meet their identified needs. The Needs Assessment Service Co-ordinators assessment completed prior to entry to the service for all residents is taken into consideration when developing the PCCP.

The Clinical leader interviewed reports there is a process for six monthly reviews of the PCCPs. The team leaders each have a list of residents for which they are responsible for. Responsibilities include the reviews of resident's individual PCCP six monthly or more often as required and arranging the multi-disciplinary reviews. Each team leader has a manual which contains all information for undertaking reviews, obligations are documented and examples of letters to family and respective assessment tools are provided. Each team leader (RN) has approximately nine residents to maintain and to ensure they receive appropriate care and management to meet their needs.

There is an area of required improvement from the previous audit which identified that changes in mobility levels of a resident were not updated to the goals set and where new goals were identified there were no dates recorded. This has been addressed and entries are current and up-to-date. A physiotherapist visits on a referral basis only and records of visits are recorded. One resident has a physiotherapist visiting weekly but the family pay for this aspect of service delivery and records are maintained.

The seven of seven residents and six of six family are positive about the staff, general practitioners and all aspects of care provided. Staff interviews consisting of four hospital, four rest home and two dementia care staff inclusive of RNs, EN and care givers report they are kept up to date with all clinical changes and that team work and continuity of care is encouraged and promoted.

The District Health Board contract requirements are met.

Tracer Methodology Rest Home:

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

Tracer Methodology hospital:

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

Tracer Methodology dementia:

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:

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 1.3.6: 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 seven of seven residents' records reviewed (two rest home, three hospital and two dementia) evidence and record interventions that are consistent with the residents' identified needs and desired goals set. Observations indicate residents are receiving appropriate care. The residents in the rest home and hospital interviewed report they are involved in their own care and feel they are treated as an individual. The two dementia residents are unable to express all their needs but staff ensure they are able to clearly anticipate and provided the necessary cares required for each resident in the dementia unit. The six of six family at interview expressed how the service meets the needs of the residents. Interventions are monitored and reviewed by the team leaders and changed if not appropriate.

The service has adequate dressing and continence supplies to meet the needs of the residents. Appropriate re-assessments are performed and are sighted in the seven of seven individual resident records reviewed.

The general practitioner interviewed discusses the improvement in care and management and consistency of this with the new management and the appointment of the clinical leader for this organisation. The pro-active approach to service delivery is evident in the meeting held recently with management and the medical practice staff on how to improve service delivery, communication and access to records to meet the needs of the residents across all services.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There is a programme developed and implemented by the activities co-ordinator for the rest home and the hospital. The programme is varied and interesting and is displayed in all areas of the facility. A letter (S) is placed beside some activities that would be satisfactory for dementia unit residents to attend or participate if they wish. Resident meetings are held three monthly and meeting minutes are available and (sighted). The activities co-ordinator has been in this role for about two years and maintains all records required but not all information has been transferred onto the individual residents records reviewed due to the allocated timeframes. Activities are provided seven days a week. In the weekend the staff are able to put a film on, take patients to the local market, keyboard club, music and games are available for interested residents.

Activities assessments for each resident undertaken at admission or later if information is needing to be gained from family/whanau. Plans are documented onto the long term PCCP in the interest and skills section and reviewed at the same time the PCCP is reviewed. External activities are provided in the community to cafes, market day, creative arts, home visits with family/whanau and shopping trips can be arranged. Independence is encouraged.

Seven of seven residents and six of six family report the activities are enjoyed by the residents and family can participate whenever they wish.

The District Health Board contract requirements are partially met.

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

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

Attainment and Risk: PA Low

Evidence:

There is an activities programme documented for the rest home, hospital and dementia unit.

The activities programme is clearly documented, implemented and displayed appropriately for the rest home and hospital level care residents. Some activities during the day are suitable for the dementia level residents to attend as able. The activities co-ordinator has been in this position for two years and is not aware of the responsibilities for having activities available and planned to cover the twenty four hour period for dementia level residents.

Finding:

There is no diversional therapist or occupational therapist to provide oversight for the dementia unit activity programme and there is no evidence of a resident 24 hour activity programme being documented or implemented for these residents.

Corrective Action:

Provide oversight of the activities programme by a qualified person and to ensure that there is an individual resident 24 hour activity programme documented and implemented.

Timeframe (days): 90 (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 team leader reviews and assessments, medical and specialist consultations are clearly documented in the seven of seven resident records reviewed. Documentation reflects that the PCCPs are evaluated at least six monthly or more often if required. Evaluations are resident focused and indicate the degree of achievement or response to supports/interventions in place and progress towards meeting the desired outcomes. If a resident is not responding to the interventions being delivered, or their health status changes, then this is discussed with the respective GP.

Resident's changing needs are clearly described in the seven of seven care plans reviewed. Short term PCCPs are available and sighted for wound care management, pain, infections, changes in mobility, changes in food and fluid intake requirements, weight loss and skin cares. These processes are documented in the medical and nursing assessments and the resident's individual progress records.

The multidisciplinary reviews are now organised by the five team leaders (RNs) and families are invited to attend or contribute to the review process. Six of six family and residents from the rest home and hospital confirm their input into the MDT meeting. The GP, activities co-ordinator, physiotherapist-assistant, cook are also involved.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Medicines are dispensed from the contracted pharmacy of choice in the robotic system packs. A safe medicines system is in place and was observed during the lunchtime medication rounds in both the hospital and the dementia unit. The medicines and the medication trolleys are securely stored when not in use. Medications are checked when the packs are delivered from the pharmacy by the registered nurses on night duty and checked when administered by the registered nurse giving out the medications at breakfast, lunch, dinner and in the late evening if required. The medication storage fridge is monitored daily to ensure the temperature is maintained appropriately.

The 14 of 14 medication records (four rest home, four dementia unit and six hospital) and signing sheets are dated, signed off and signatures can be verified with the specimen signature list sighted. Allergies and sensitivity are recorded and bright coloured stickers are used to alert staff as needed. Stickers are also available for duplicate name, Warfarin and for controlled drugs to be administered for an individual resident as charted. There is evidence of pharmacy input and audits being performed six monthly and the GPs review all medications three monthly or more often as required. The GP interviewed ensures this occurs. The medications are printed out by the pharmacy and the GPs sign off all medications individually to meet legislative requirements. The registered nurses and all health care assistants have completed annual medication competencies. The registered nurse interviewed administers the medications on all shifts. A record of medication competencies being completed is in the front of the individual medication record books and on the education training spreadsheet sighted.

The clinical leader records any medications returned to the pharmacy and this is a new initiative for quality purposes. The clinical leader or team leaders order the medications as required. There is a system in place for checking the controlled drugs with two registered nurses, or one registered nurse and one enrolled nurse, or the clinical leader and one registered nurse. The controlled drugs are checked weekly and balances are correct and able to be verified.

There are no residents self-medicating. Two registered nurses at interview understand the policy and process should this situation arise. The clinical leader confirms there are no standing orders.

There is one area of required improvement for medicine management identified due to the names of the general practitioners, contact details and registration numbers not being consistently recorded on the medication records reviewed for the rest home level residents. Details are clearly recorded on the dementia unit and hospital medication records sighted.

The District Health Board contract requirements are partially met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

The 14 of 14 medication records reviewed (four dementia unit, four rest home and six hospital) evidenced all appropriate details on the medication records for the hospital and dementia unit residents. There is inconsistency noted at the time of review in relation to the general practitioner information details on the rest home medication records reviewed. The general practitioner name, contact details or registration numbers are not documented.

Finding:

The name of the general practitioner, the contact details and the registration numbers are not consistently documented on the rest home level residents' medication records reviewed.

Corrective Action:

Ensure that the name of the general practitioner, contact details and the registrations number is documented on the medication records for the rest home residents.

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and procedures are available and sighted that include food safety and all kitchen services. The kitchen services are managed by an experienced cook who has been at this facility for eleven years. There are three cooks and two kitchen hands to cover this service. Seven days a week there is one cook and two kitchen hands between the hours of 7am and 6.30pm. The main cook orders all the food and is responsible for the daily temperature monitoring. The business and care manager interviewed is consulted if required. Food is stored effectively and safely. All equipment and resources are readily available inclusive of personal protective items such as gloves, aprons and hats.

The team leader and registered nurses are responsible for ascertaining the nutritional needs of each resident on admission to this service. A copy of the assessment and dietary requirements is provided to the cook. Any special diets or requests are noted on the whiteboard for staff to view when preparing the individual meals.

There is a dining room in each service area. The hospital dining room is in close proximity to the main kitchen so food is served directly from the kitchen. A trolley is used to transport the food to the rest home and the dementia units for lunch and dinner. Three health care assistants are observed assisting the residents in the hospital dining room at lunchtime. The kitchen hand serves the meals in the rest home.

Evidence is sighted of menu planning and menu reviews for the summer and winter (the organisation's dietitian reports are available) cleaning schedules and audit requirements being completed. The menu review is based on the dietitian NZ audit for nutrition and dietary variety. Ministry of Health guidelines for older adults and Australian

standardised definitions for texture modified food and fluids. The menu plans rotate four weekly. Evidence of all staff attending relevant education on infection control, first aid and safe food handling certificates. Interviews with six of six family and seven of seven residents indicate that there is overall satisfaction with the food service 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 1.4.2: 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 26 August 2015). There have been no building modifications since the last audit.

There is a planned maintenance schedule implemented.

The lounge areas are designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounges on the day of the audit. The areas are suitable for residents with mobility aids and a secure unit for residents with dementia who require this. The unit has an outdoor circular garden/path with shade cloth. The area is being further developed to provide a larger outside area for residents.

The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programme two yearly and this is up to date (last completed 2014).

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:**

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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.)

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 clinical leader oversees the restraint minimisation and safe practice for this service. The restraint co-ordinator at interview has a good understanding of restraint and the use of enablers use. Staff interviewed seven of seven understand that enabler use is voluntary and the least restrictive option to meet the needs of a resident. There are six residents currently using an enabler (bedrails) all for safety purposes only. Training is provided to all staff annually as per Oceania protocol.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Surveillance frequency and type is set out in Oceania policy and is overall determined by the services infection control policies and procedures that are reflective of this aged care residential care service. The infection surveillance data is required for the monthly clinical indicators. The services infection control manual is accessible to guide staff.

Infection control data is collected on relevant types of infection such as urinary tract infections, lower respiratory infections, flu, chest infections, skin and wound infections, oral infections and other infections. The monthly data collected is forwarded to head office and the clinical indicators are then provided back in the form of a report to the infection control coordinator who at this facility, is the clinical leader. The infection control report is provided to the quality meeting with the benchmarking evidence and any recommendations. Results are fed back to the quality meeting and to staff at the monthly staff meetings. Minutes of the staff meetings are available and the minutes clearly evidence infection control on the set agenda. Surveillance graphs are used as staff can understand the results in this form rather than being summarised.

The seven of seven staff interviewed report they are kept well informed and understand their responsibilities for reporting any signs and symptoms of a resident having an infection to the registered nurse team leaders or to the clinical leader directly.

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.)