Oceania Care Company Limited - Ohinemuri Care Centre

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of 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).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity: Oceania Care Company Limited

Premises audited: Ohinemuri Care Centre

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 13 October 2015 End date: 14 October 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 58

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Ohinemuri Care Centre (Oceania Care Company Limited) can provide care for up to 68 residents.

This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. The audit process included the review of policies and procedures, and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The relieving business and care manager is responsible for the overall management of the facility and is supported by the acting clinical leader and regional and executive management team. Service delivery is monitored.

Improvements are required to resident agreements and activity plans.

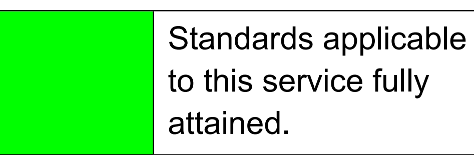
Consumer rights

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.

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. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Complaints are addressed within timeframes in policy with improvements made if required.

Organisational management

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.

Oceania has a documented quality and risk management system that supports the provision of clinical care and support at the service. Policies are reviewed at head office and quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status reports.

Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators.

There are human resource policies implemented around recruitment, selection, orientation and staff training and development.

Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

Continuum of service delivery

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.

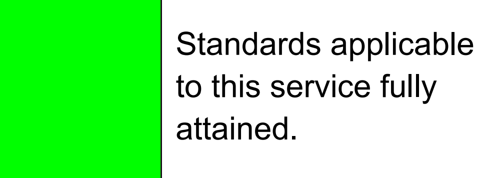
Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a guide for all staff while the long term care plan is developed over the first three weeks of residents' admission. Care plans reviewed were individualised and risk assessments completed. Residents' response to treatment is evaluated and documented. Relatives are notified regarding changes in a resident's health condition.

Activities are appropriate to the age, needs and culture of the residents and support their interests and strengths. The residents and families interviewed expressed being satisfied with the activities provided.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. The service uses an electronic medication system. Medication management processes and practices are in line with legislation and contractual requirements. The general practitioner completes regular and timely medical reviews of residents and medicines. Medication competencies are completed annually for all staff that administer medications.

The facility utilises four weekly rotating summer and winter menus reviewed by a dietitian.

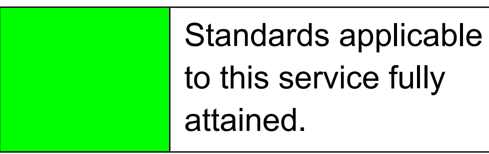
Safe and appropriate environment

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.

All building and plant comply with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes equipment and electrical checks. The environment is appropriate to the needs of the residents. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

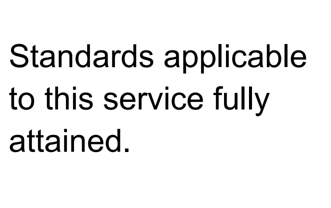
Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

Restraint minimisation and safe practice

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.

The restraint minimisation programme defines the use of restraints and enablers. The restraint register is current. The service does not use enablers. Policies and procedures comply with the standard for restraint minimisation and safe practice. Assessment, documentation and monitoring maintaining care and reviews are recorded and implemented, and restraint risks are identified. Residents using restraints had no restraint-related injuries. Staff members receive adequate training regarding the management of challenging behaviour and restraint use.

Infection prevention and control

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.

The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. Staff education in infection prevention and control is conducted according to the education and training programme and recorded in staff files.

Infections are investigated as part of the quality programme and appropriate antibiotics were prescribed according to sensitivity testing. Data relating to infections are collected monthly for benchmarking. Appropriate interventions are in place to address infections. Staff members were able to explain how to break the chain of infection.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	1	1	0	0
Criteria	0	99	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	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. All staff have had training in 2015. Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs. The auditors noted respectful attitudes towards residents on the days of the audit.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care. All resident files identified that informed consent is collected. Interviews with staff confirmed their understanding of informed consent processes.

		The service information pack includes information regarding informed consent. The registered nurse or the acting clinical leader discusses informed consent processes, with residents and their families/whanau, during the admission process. The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files noted that all had appropriately signed advanced directives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	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. 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 2015. There are two community members, independent of the service, who facilitate the residents' meetings every two to three months. There is also access to the Health and Disability Advocate if requested by the management team and/or residents. Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families interviewed confirm they could visit at any time and are always made to feel welcome. Residents are encouraged to be involved in community activities and to maintain family and friends networks. Residents are encouraged to maintain friendships already developed in the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and	FA	The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved.

upheld.		Evidence relating to each lodged complaint is held in the complaints folder. Two complaints reviewed in 2015 indicate that complaints are investigated promptly with the issues resolved in a timely manner. Residents and family members state that they would feel comfortable complaining. The residents interviewed did not have any complaints about the service but stated that if they did, they would feel that these would be addressed. There have been no complaints lodged with the Health and Disability Commission since the previous audit. There have been no complaints with other external authorities since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The relieving business and care manager, acting clinical leader or a registered nurse discuss the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code can also be held at the resident meeting as sighted in meeting minutes reviewed in 2015. Residents and family interviews confirm their rights are being upheld by the service. The information pack includes information around rights and this can be produced in a bigger font if required. Information is given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and family members are able to describe their rights and advocacy services, particularly in relation to the complaints process.
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.	FA	The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment gains details of peoples' beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated. A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner, with strategies documented to manage any inappropriate behaviour if there are any issues for a resident. The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings.

		Health care assistants report that 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. This was observed on the days of the audit. Residents and families confirm that residents' privacy is respected. The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports for 2015 or on incidents reviewed in residents' files. Residents, staff, family and the general practitioner confirm that there is no evidence of abuse or neglect. Resident files reviewed identified that cultural and /or spiritual values and individual preferences are met.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The service implements the Māori 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 Māori health plan. The service has links to local kaumātua and Māori services are through the district health board. There are staff who identify as Māori and staff report that specific cultural needs are identified in the residents' care plans. There are Māori residents currently using the service with one resident stating that their cultural needs are well catered for. The file reviewed of a resident who identifies as Māori confirms that there is a cultural assessment with the plan including cultural needs. Staff are aware of the importance of whānau in the delivery of care for the Māori residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies each resident's personal needs from the time of admission. This is achieved with the resident, family and/or their representative. There is a culture of choice with the resident determining when cares occur, times for meals and choices in meals and activities. Staff work to balance service delivery, duty of care and resident choice. Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the resident's cultural values and beliefs. This information is used to develop a care plan. Staff are familiar with how translating and interpreting services can be accessed. Residents in the service do not require interpreting services. There is a focus on ensuring that activities for younger residents are relevant to their abilities.

		The activities coordinator and each individual resident work to identify individual activities that encourage independence. This includes a focus on activities and independence for residents in the dementia unit.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility implements the 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 in staff files reviewed relevant to the role held by the staff member. The orientation and employee agreement provided to staff on induction include standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the health care assistants' role and responsibilities.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Ohinemuri Care Centre implements Oceania policies to guide practice. These policies are aligned with the health and disability services standards and are reviewed bi-annually. A quality framework supports an internal audit programme. Benchmarking occurs across all the Oceania facilities. There is a training programme for all staff and managers are encouraged to complete management training. There are monthly regional management meetings. Specialised training and related competencies are in place for the registered nursing staff with a review of staff files indicating that these are completed annually by all staff relevant to their role. Residents and families interviewed expressed a high level of satisfaction with the care delivered. Consultation is available through the organisation's management team that includes registered nurses, the clinical and quality manager, regional operations manager and a dietitian. The key projects implemented in the past year included the following: refurbishment of internal areas, including refurbishment of the kitchen; review of the activities programme, with a focus on the diversional therapist providing a 24-hour programme in the dementia unit.
Standard 1.1.9: Communication	PA	Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	Moderate	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, as evidenced in completed accident/incident forms. Family contact is recorded in residents' files. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member and could attend the resident meetings. Residents are expected to sign an admission agreement on entry to the service. When signed, this provides clear information around what is paid for by the service and by the resident. Most are signed on the day of admission.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ohinemuri Care Centre is part of the Oceania Care Company Limited with the executive management team, including the chief executive, general manager, regional operations manager and clinical and quality manager, providing support to the service. Communication between the service and managers takes place on at least a monthly basis with the clinical and quality manager providing support during the audit. The monthly business status report provides the executive management with progress against identified indicators. There is a clear mission, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training provided annually. The facility can provide care for up to 68 residents. This includes 22 hospital, 34 rest home (inclusive of seven dual beds), and 12 dementia. Three residents were identified as being young people with disability (under 65 years of age). The relieving business and care manager is responsible for the overall management of the facility. The previous business and care manager has resigned and a new business and care manager has been appointed. The business and care manager is a registered nurse.
Standard 1.2.2: Service Management 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	FA	In the absence of the relieving business and care manager, the acting clinical leader is in charge with support from the regional operations manager and clinical and quality manager (organisational). The new clinical manager has been appointed and is a registered nurse. Health CERT has been informed of the appointment of the acting clinical leader and of the appointment of the new clinical manager.

consumers.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Ohinemuri Care Centre uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice. 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. New and revised policies are presented to staff to read and staff sign to say that they have read and understood them. Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed. There is documentation that includes collection, collation, and identification of trends and analysis of data. Meeting minutes evidence communication with all staff around all aspects of quality improvement and risk management. There are also two to three monthly resident meetings that keep residents informed of any changes. Staff report that they are kept informed of quality improvements. There is an annual family and resident satisfaction survey with a high level of satisfaction documented. The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly. A health and safety representative interviewed confirmed knowledge of the role.
Standard 1.2.4: Adverse Event Reporting 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	FA	The relieving 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, sentinel events, infectious disease outbreaks and changes in key management roles. Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and are able to describe the importance of recording near misses.

manner.		Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	The registered nurses and the acting clinical leader hold current annual practising certificates along with other health practitioners involved with the service. Staff files included appointment documentation that includes, signed contracts, job descriptions, reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal. All staff complete an orientation programme and health care assistants are paired with a senior health care assistant (HCA) for shifts or until they demonstrate competency on a number of tasks, including personal cares. HCAs confirmed their role in supporting and buddying new staff with a new staff member interviewed confirming that they had a comprehensive orientation programme. Annual competencies are completed by care staff including hoist, oxygen use, hand washing, wound management, medication management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower. The organisation has a mandatory education and training programme. Staff attendances are documented. Education and training hours is at least eight hours a year for each staff member. There are nine health care assistants who work in the dementia unit and all have completed the dementia training, except one, who is always on duty with a senior staff member who has completed training around dementia. There are six other HCAs, the activities coordinator and the diversional therapist who have completed dementia training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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 reflected staffing levels that met resident acuity and bed occupancy. There are 73 staff including, clinical staff, an activities coordinator and household staff. There is always a registered nurse (RN) on each shift and always two staff in the dementia unit. The acting clinical leader and two RNs provide 24-hour on call services with the call bells in the dementia unit connected to the rest home. Staff in the dementia unit confirm that the RN from the hospital and health care assistants from the rest home respond to any emergency bells

		rung from the dementia unit. Rosters reviewed indicate that staff are replaced when on leave. There is no bureau available in the area and casual staff provide cover when staff are on leave. Residents and families interviewed confirm staffing is adequate to meet the residents' needs.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family. There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of residents' records. Files, relevant resident care, and support information could be accessed in a timely manner. Entries are legible, dated and signed by the relevant health care assistant, registered nurse or other staff member, including designation. Resident files are protected from unauthorised access by being locked away in an office. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder with medication. Staff interviewed state that they read the long-term plans at the beginning of each shift and are informed of any changes through the handover process.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents' entry into the service is facilitated in a competent, equitable, timely, and respectful manner. Information packs are provided for families and residents to the rest home, hospital and the dementia unit, prior to admission. The facility requires all residents to have needs assessment service coordinators (NASC) assessments prior to admission, to ensure they are able to meet the resident's needs. Interviews confirm that the registered nurses (RNs) admit new residents into the facility. Evidence of completed admission records was sighted. The RNs receive hand-over from the transferring agency, for example the hospital and utilise this information in creating the appropriate long term care plan for the resident.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The ACL reported that they include copies

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		of the resident's records; including GP visits; medication charts; current long term care plans; upcoming hospital appointments, and other medical alerts when a resident is transferred to another health provider.
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.	FA	Medicine management policies and procedures are in place and implemented. They include processes for safe and appropriate prescribing, dispensing and administration of medicines. The medication area is free from heat, moisture and light, with medicines stored in original dispensed packs, in a secure manner. Medicine charts reviewed listed all medications the resident was taking, including name, dose, frequency and route to be given. All entries were dated and allergies recorded. All charts had photo identification. Three monthly GP reviews were evident. Medication reconciliation policies and procedures are implemented. Medication fridges are monitored weekly. Controlled drugs are kept inside a locked cupboard and the controlled drugs register was current and correct. Sharps bins were sighted. Unwanted or expired medications are collected by the pharmacy. Medication administration was observed during lunch time in the hospital, the rest home and the dementia unit. The staff member checked the identification of the residents, completed checks of the medicines, administered the medicines, and then signed off after the resident took the medicines. Education in medicine management is conducted. Medicine management competency testing includes theory and practice. All staff members responsible for medicine management complete annual competencies. Self-administration of medicine policies and procedures are in place and sighted. There were two residents who self-administered their own medication in the rest home. The residents are assessed to be competent for self-administration of medicines, are checked by staff to ensure they take the medicines and they have secure storage for their medicines in their rooms.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The residents' individual food, fluids and nutritional needs are met. Residents are provided with a balanced diet which meets their cultural and nutritional requirements. The meals are prepared and cooked on-site. The menu was reviewed by the dietitian in September 2015. The menu review is based on nutritional guidelines for the older people in long-term residential care. A dietary assessment is completed by the RNs or ACL on admission. This information is shared with kitchen staff to ensure all needs, food allergies, likes, dislikes and special diets are catered for. The facility provides modified diets e.g. puree diets to meet the dietary needs of the

		residents. A white board in the kitchen also contains important reminders about modified diets as well as preferences of residents. The cook interview confirmed documentation of kitchen routines. Nutrition and safe food management policies define the requirements for all aspects of food safety. A kitchen cleaning schedule is in place and implemented. Labels and dates on all containers and records of food temperature monitoring are maintained. The chiller, fridge and freezer temperatures are monitored. The cook and the kitchen assistant have current food handling certificates. All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. The service provides snacks in-between meals for those that may need something extra to eat.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	Ohinemuri has a documented process for the management of declining residents entry into the facility. Records of enquiry are maintained and in the event of decline, information is given regarding alternative services and the reason for declining services. The scope of services provided is identified in the admission agreement and communicated to prospective residents and their families (refer to criteria 1.1.9.1). This was confirmed during the interview with residents and their families. The acting clinical leader (ACL) assesses the suitability of residents and uses an enquiry form with appropriate questions regarding the specific needs and abilities of each resident. When residents are not suitable for placement at the service, the family and or the resident are referred to other services, depending on their level of needs.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The resident’s needs, support requirements, and preferences are collected and recorded within required timeframes. The RNs or the ACL complete a variety of risk assessment tools on admission. The service complete InterRAI assessments for all new residents. Additional assessments were sighted in the residents’ files including the medical assessment completed by the GP and recreational assessment completed by the activities coordinators (AC) or the diversional therapist (DT). Baseline recordings are recorded for weight management and vital signs with monthly monitoring. Staff interviews confirmed that the families are involved in the assessment and review processes. The outcomes of the assessments are used in creating an initial care plan, the long term care plan and a recreational plan for each resident.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long term care plans reviewed were resident focused and integrated. The resident files had sections for the resident's profile, details, observations, long term care plans, monitoring and risk assessments. Interventions sighted were consistent with the assessed needs and best practice. Goals were realistic, achievable and clearly documented. The service recorded intervention for the achievement of the goals.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents receive adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions are documented for each goal in the long term care plans. Interview with the GP confirmed clinical interventions were effective and appropriate. Interventions from allied health providers were included in the long term care plan, this included: the speech language therapist; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist. Residents and family involvement in the development of goals and review of care plans are encouraged. Multidisciplinary meetings are conducted by the ACL to discuss and review long term care plans. All resident files reviewed were signed by either the resident or by their families.
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	The facility employs a diversional therapist (DT) and four part time activity coordinators (AC's) for the development, implementation and review of the activities programmes. The programmes confirm that independence is encouraged and choices are offered to residents. They provide different activities addressing the abilities and needs of residents in the hospital, rest home and the dementia unit, including additional activities for residents who are younger than 65. The service has three residents under the age of 65. Sufficient equipment is provided. Activities attendance records are maintained and resource materials are accessible for the staff to utilise. The residents' files reviewed during the on-site audit had past activities identified, however two residents' files did not have current abilities and activities identified. Residents and family confirmed they were satisfied with the activities programmes. Each resident had access to the activities programme. Review of activity plans are completed every six months, as part of the multi-disciplinary review, or when the condition of the resident changes.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The residents' files reviewed showed PCCP's have six monthly reviews completed. Clinical reviews are documented in the multi-disciplinary review (MDR) records, which include input from the GP, RNs, HCAs, DT and other members of the allied health team. Daily progress notes are completed by the HCAs and RNs. Progress notes reflect daily response to interventions and treatments. Short term care plans are developed for acute problems for example: infections; wounds; falls and other short term conditions. Changes to care are documented and residents are assisted in working towards goals. Reviews include the three monthly medication reviews by the GP and review and medicines reconciliation when residents enter the service from another health provider. Evaluations are documented, resident focused and indicate the degree of response to interventions and the progress towards meeting the resident's goals.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The ACL stated that residents were supported in access or referral to other health and disability providers. The RN's manage referrals for residents to the GP, dietitian, physiotherapist, speech language therapist and mental health services. The GP confirmed involvement in the referral processes. The review of residents' files included evidence of recent external referrals to the physiotherapist and specialists.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	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. There is provision and availability of protective clothing and equipment that is appropriate to the recognised risks, 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.

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed with an expiry date of May 2016. There have been no building modifications since the last audit. There is a planned maintenance schedule implemented. The following equipment is available: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There is an annual test and tag programme and this is up to date with checking and calibrating of clinical equipment annually. Interviews with staff and observation of the facility confirmed there is adequate equipment. There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are internal courtyards and grass areas with shade, seating and outdoor tables. The dementia unit is a secure unit with a circular garden and a number of entry/exit points into the facility from the courtyard.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Residents and family members report that there are sufficient toilets and showers. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	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, including hoists, at least two staff and the resident. All residents living in the dementia unit have a single bedroom. Rooms can be personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own. There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.

		Some residents have a larger room to accommodate specific aids.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The service has lounge/dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely. There are dining areas with ample space for residents. Residents can choose to have their meals in their room. The dementia unit has its own lounge/dining area that is also used for activities.
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.	FA	Laundry is completed on site with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry with separate doors to take clean and dirty laundry in and out. Laundry staff are required to return linen to the rooms. Residents and family members state that the laundry is well managed. The laundry staff interviewed confirmed knowledge of their role, including management of any infectious linen. There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	An evacuation plan was approved by the New Zealand Fire Service in July 2014. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. There is always at least one staff member with a first aid certificate on duty. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, emergency lighting and gas BBQs.

		An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways and dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells. Staff state that rest home staff respond immediately if there are emergency bells rung in the dementia unit. The doors are locked in the evenings. Staff complete a check in the evening that confirms that security measures have been put in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area for residents. Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.
Standard 3.1: Infection control management 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.	FA	The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The infection control committee has representatives in each area of the service management team. This group meets monthly and infection control matters are discussed at the monthly staff and quality meetings. There is an infection control programme that was last reviewed during March 2015. When a resident presents with an infection, staff send specimens to the laboratory for sensitivity testing. The GP prescribes antibiotic as per sensitivity, confirmed during interview. The RNs create short term care plans and review the effectiveness of the prescribed antibiotics when the treatment is completed. Infections are discussed during staff meetings, sighted meeting minutes.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the	FA	There are adequate human, physical, and information resources to implement infection control programme and meet the needs of the organisation. Hand washing signs were sighted around the facility to remind staff and residents of the importance of proper hand washing. The facility maintains regular in-service training for infection control including, standard precautions, personal protective equipment, cleaning, infectious diseases and hand washing. Training

infection control programme and meet the needs of the organisation.		records that are aligned with the training planner were sighted
Standard 3.3: Policies and procedures 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.	FA	Documented policies and procedures for the prevention and control of infection reflect accepted good practice and relevant legislative requirements and are readily available and implemented at the facility. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The organisation provides relevant education on infection control to all service providers, support staff and residents. The infection control education is provided by either by the ACL or external resource speakers. Residents interviewed were aware of the importance of hand washing. Staff members confirmed receiving infection control training and could explain the importance of hand washing in the prevention and control of infection.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The acting clinical leader (ACL) is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided. Information gathered is clearly documented in the infection log maintained by the acting clinical leader/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities and methods that have been specified in the infection control programme. Infection control processes are in place and documented. The infection control surveillance register included monthly infection logs and antibiotics use. The organisation had an internal benchmarking system. Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the staff meeting.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Staff interviews, observations and review of documentation, demonstrated that the use of restraint was actively minimised. Restraints used in the facility included lap belts, restraint briefs and bedrails. There were two residents using restraints and no residents using enablers. Residents who used restraints had risk management plans in place. The restraints were documented in their long term care plans. There were no restraint related injuries reported. The service has a documented system in place for restraint use, including a current restraint register. Records included assessments, consents, monitoring and evaluation forms, consent forms, authorisation and plans forms. Reasons for restraint use were considered and documented in the restraint assessments. One of the RNs is the restraint coordinator.
Standard 2.2.1: Restraint approval and processes 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.	FA	The facility maintains a process for determining approval of all types of restraints used. The restraint coordinator completes a restraint assessment which is then discussed with the GP prior to commencement of any restraints. The restraint committee is defined in the restraint minimisation and safety policies and procedures. The duration of each restraint is documented in the restraint plans of residents. Health care assistants (HCAs) are responsible for monitoring and completing restraint forms when the restraints are in use. Evidence of on-going education regarding restraint and challenging behaviour was evident. Staff members were made aware of the residents using restraints during monthly staff meetings. This was confirmed during staff interviews.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessments include restraint related risks. The service recorded underlying causes for behaviour that required restraint with a focus on culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. Restraint risks and monitoring timeframes are identified in the restraint assessment records.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Before resorting to the use of restraint, the restraint coordinator utilises other means to prevent the resident from incurring injury for example, the use of sensor mats. Restraint consents are signed by the GP, family and the restraint coordinator. Restraints are incorporated in the long term care plans and reviewed three monthly. The restraint register is up to date. The GP confirmed that the facility uses restraint safely.

Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint is still required. The family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. Restraint minimisation and safe practices are reviewed.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The facility demonstrates the monitoring and quality review of their use of restraints. Their audit schedule was sighted and included restraint minimisation reviews. The content of the internal audits included the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff knowledge and good practice was also included in the quality reviews.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Moderate	Six of eight files reviewed included a resident agreement signed on the day of admission. The relieving business and care manager stated that the two residents who do not have a resident agreement signed do not have family engaged in their care. This includes one resident who is in the dementia unit. The service is working to identify an enduring power of attorney or welfare guardianship for the dementia resident. An advocate to support the other resident who is competent has not been sought.	Two of the eight files reviewed do not have a signed resident agreement.	Ensure that all residents have a signed resident agreement. 30 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain	PA Low	Eight resident files were reviewed for the activity assessments, activity plans and activity plan reviews. All the files included identification of past interests and abilities. However, two of the residents did not have their present abilities and interests identified as part of their activities plan.	Two of eight activity plans did not identify the	Activity plans to include the resident’s current

strengths (skills, resources, and interests) that are meaningful to the consumer.			residents' current interests or abilities.	abilities and interests. 90 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message "no data to display" then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.