

# Oceania Care Company Limited - Eversley Lifestyle Care & Village

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## 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:** Eversley Rest Home and Village

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 1 March 2016 End date: 2 March 2016

**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:** 49

# Executive summary of the audit

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## 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

This certification audit was undertaken to monitor compliance with the Health and Disability Services Standards and the district health board contract. Eversley Rest Home and Village is operated by Oceania Care Company Limited. The service includes a dementia unit.

Eversley Rest Home and Village can provide care for up to 50 residents. On the days of this audit there were 49 residents. The audit process included review of policies and procedures, sampling of resident and staff files, observations, interviews with residents and their families, management, staff and a general practitioner. Three are requirements for improvement relating to informed consent, assessments and medicines management.

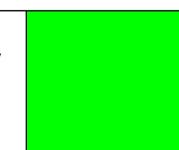
## Consumer rights

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 low risk.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights information (the Code of Rights), the complaints process and the Nationwide Health and Disability Advocacy Service, were accessible. This information is given to residents' and their families on admission to the facility. Residents and family interviews confirmed their rights are met. Interviews confirmed that staff are respectful of their needs and communication is appropriate.

Residents and family interviewed confirmed consent forms are provided. Staff members confirm that time is provided if any discussions and explanation are required. The business and care manager is responsible for management of all complaints. There is a requirement for improvement relating to resuscitation directives.

## 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.
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Oceania Care Company Limited is the governing body and is responsible for the service provided at Eversley Rest Home and Village. The business and care manager is appropriately qualified and experienced. The clinical manager is new to the role and responsible for oversight of clinical care. HealthCERT received notification of this appointment.

Quality improvement data is collected, collated, analysed and reported through the use of their national quality system. Corrective action plans are developed and address areas identified as requiring improvement. Risks are identified and the hazard register is up to date.

Adverse events are documented on incident and accident forms and areas requiring improvement are identified. Policies and procedures relating to human resources management processes govern their practices. Staff records reviewed provide evidence that their human resources processes are followed. Staff education records confirmed in service education is provided. The business and care manager, who is also a registered nurse, validates annual practising certificates for health professionals who require registration with their professional bodies.

A documented rationale for determining staffing levels and skill mix was reviewed. The clinical manager is available after hours if required for clinical support. Care staff, residents and family reported there are adequate staff available. Resident information is entered into a register in an accurate and timely manner.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and family interviewed confirm their input into care planning and access to a typical range of life experiences and choices.

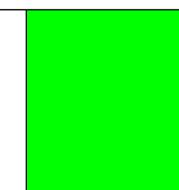
A sampling of residents' clinical files validates the service delivery to the residents. Initial assessments and initial care plans are conducted on admission. There is a requirement for the interRAI assessments to be completed within a three week timeframe of resident's admission to the facility. The long term care plans are completed within the required timeframes and reviewed six monthly. Where progress is different from expected, the service responds by initiating changes to the long term care plan or recording the changes on a short term care plan.

Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

The medication management system requires improvement relating to the security of the rest home medication room, checking of medication upon arrival to the facility and prescribing of as required medicines. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. There were no residents self-administering medicines at the facility on audit day.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. There is a central kitchen and on site staff that provide the food service. The kitchen staff have completed food safety training.

## 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.
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All resident bedrooms provide single accommodation and the majority of residents are sharing communal bathroom facilities. Residents' rooms have adequate personal space. Lounges and dining areas are available for residents and external areas are available for sitting. Shade is provided.

The facility has an escalation call bell system in place. The service has security systems in place to ensure resident safety. Sluice facilities are provided and protective equipment and clothing is provided and used by staff.

Chemicals, linen and equipment are safely stored. Laundry services are provided by another Oceania facility and delivered to the service. The service has a current building warrant of fitness. The preventative and reactive maintenance programme includes equipment and electrical checks.

## 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.
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Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use will be activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There were no residents using restraint or requiring enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour has been provided.

## 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.
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The infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. The policies and procedures guide staff in all areas of infection control (IC) practice. New employees are provided with orientation in IC practices and there is ongoing IC education available for all staff.

IC is a standard agenda item at the facility's meetings. Staff are familiar with IC measures at the facility.

The IC surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided. The IC surveillance data is collated, analysed and reports of the surveillance results are communicated to Oceania head office and staff and are benchmarked against other Oceania facilities.

## 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)
<b>Standards</b>	0	42	0	2	1	0	0
<b>Criteria</b>	0	90	0	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff received education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service. This also forms part of their annual mandatory education programme. Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice especially regarding maintaining of residents' privacy, providing residents with choices, encouraging independence.</p> <p>The information pack provided to residents on entry includes information on how to make a complaint and brochures on the code advocacy services. Care staff were respectful towards residents and family members.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Low	<p>The service has systems in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The clinical manager and business and care manager reported informed consent is discussed and recorded at the time the resident is admitted to the facility; however there is a requirement for improvement relating to directives for resuscitation in the dementia unit having been signed by the enduring power of attorney (EPOA). Staff</p>

		<p>interviewed demonstrated a good understanding of informed consent processes.</p> <p>Residents and family interviewed confirmed they have been made aware of and understand the principles of informed consent. Residents/family are provided with various consent forms on admission for completion as appropriate and these were reviewed on resident's files. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these were reviewed on resident's files.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>The service has appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. The facility manager advised the independent advocate visits the service regularly. Care staff interviewed demonstrated an understanding of how residents can access advocacy and support persons.</p> <p>Residents and family interviewed confirmed that advocacy support is available to them, if required. They also confirmed this information was included in the information package they received on admission, sighted. Observations provided evidence the nationwide advocate details are displayed along with advocacy information brochures. Admission information was reviewed and provided evidence advocacy, complaints and information on The Code is included.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and family members interviewed confirmed they can have access to visitors of their choice. The service has a van available to take residents on community visits and outings. Some residents go out independently on a regular basis. Visitors' policy and guidelines are available to ensure resident safety and wellbeing is not compromised by visitors to the service. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The business and care manager is responsible for complaints. The service has appropriate systems in place to manage the complaints processes. The service records complaints, the investigation of complaints, the resolutions - including acknowledgement of receiving the complaint, and a closing letter addressed to the complainant with a closing-out date and sign-off. The business and care manager advised there have been no complaints to the Health and Disability Commissioner, the district health board (DHB),</p>

		<p>Accident Compensation Corporation (ACC), coroner or HealthCERT since the previous audit at this facility.</p> <p>Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. The complaint process was readily accessible and displayed and the complaints register was up to date. Residents and family interviewed confirmed having an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues they have during these meetings, confirmed during interviews.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), and information on the advocacy service are available and displayed in English and Te Reo. The admission information packs were reviewed and included information on the Code, advocacy and complaints processes. Residents and family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to admission.</p> <p>Residents and family interviewed received copies of the Oceania Handbook. Interviews confirmed explanations regarding their rights occurred on admission. Families and residents are informed of the scope of services. This is included in the service agreement and admission agreements.</p> <p>Residents interviewed confirmed they had access to an advocate, if needed. The business and care manager advised that an advocate visits the facility on a regular basis and is also responsible for taking resident meetings. The completed resident and family survey questionnaires indicated residents are aware of their rights and are satisfied with this aspect of service delivery.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff receive training on abuse/neglect as part of the in-service education programme. Staff were observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Care staff interviewed demonstrated an awareness of residents' rights and the maintenance of professional boundaries. Residents were observed being treated with respect by care staff during this audit. This was confirmed during review of the completed satisfaction survey questionnaires. Interview with the general practitioner (GP) confirms not having any concerns relating to abuse and neglect</p>

		<p>of residents.</p> <p>Activities in the community are encouraged and the relief business and care manager advised some of the residents attend community events independently. Values, beliefs and cultural aspects of care were recorded in residents' clinical files reviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>The Māori health plan describes that the holistic view of Māori health is to be incorporated into the delivery of services. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. The service employs staff who identify as Māori where possible. Access to Māori support and advocacy services is available if required from a local provider of health and social services.</p> <p>Staff members also provide cultural advice and support for staff if required. A cultural assessment is completed as part of the care plan for all residents. Specific cultural needs are identified in the residents' care plans and this was sighted in files reviewed. Staff were aware of the importance of whānau in the delivery of care for the Māori residents. Whānau are able to be involved in the care of their family members.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Documentation provided evidence that appropriate culturally safe practices were implemented and maintained, including respect for residents' cultural and spiritual values and beliefs. The organisations documentation lists the details on how to access appropriate expertise including cultural specialists and interpreters. Residents' files demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whānau contact details. The service had one resident identifying as Māori.</p> <p>Residents interviewed confirmed their culture, values and beliefs are being respected, and their spiritual needs are met. During interview, care staff demonstrated an understanding of cultural safety in relation to care and confirmed that processes are in place for residents to have access to appropriate services, ensuring their cultural and spiritual values and beliefs are respected.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or</p>	FA	<p>Oceania's policies and procedures outline processes to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct.</p>

<p>other exploitation.</p>		<p>Staff files reviewed included copies of the code of conduct that all staff are required to adhere to. Conflict of interest issues, including the accepting of gifts and personal transactions with residents are included in the staff training, policies and procedures. Expected staff practice is outlined in job descriptions and employment contracts, which were reviewed on staff files.</p> <p>Review of the adverse events reporting system, complaints register and interview of the business and care manager indicates there have been no allegations made by residents of unacceptable behaviour by staff members. Residents and family interviewed reported that staff maintain appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has systems in place to ensure staff receive a range of opportunities which promote good practice within the facility. Education is provided by specialist educators as part of the in-service education programme which is overseen by the clinical manager with input from the business and care manager and the regional clinical quality manager. The district health board (DHB) also provides education as part of the in-service education programme.</p> <p>The clinical quality manager, the business and care manager and the clinical manager/registered nurse described the process for ensuring service provision is based on best practice, including access to education by specialist educators. Staff interviewed confirmed an understanding of professional boundaries and practice.</p> <p>Documentation reviewed provided evidence that policies and procedures are based on evidence based rationales.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Open disclosure policies and procedures were in place to ensure staff maintain open, transparent communication with residents and their families in both the rest home and the dementia unit. The residents' files reviewed provided evidence that communication with family members was being documented in residents' records. There was evidence of communication with the general practitioner (GP) and family following adverse events.</p> <p>The business and care manager advised access to interpreter services is available if required via the district health board if required. They also advised there were no residents who required interpreter services. Residents interviewed confirmed that they are aware of the staff that are responsible for their care and staff communicate well with them. Admission agreements reviewed were signed and dated on admission.</p>

<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Oceania Care Company Limited's vision, values, mission statement and philosophy are displayed at the entrance to the facility. The organisation has systems in place recording the scope, direction and goals of the organisation. The business and care manager and the clinical manager provide monthly reports to the support office relating to governance through the Oceania intranet. Governance reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators, as sighted.</p> <p>The service has a business and care manager, supported by a newly appointed clinical manager and regional clinical quality manager. The clinical manager/RN is employed in a full time position to work with the business and care manager and has responsibility for the management of compliance with all clinical matters. The clinical manager's appointment was confirmed with HealthCERT, the auditors sighted a copy of the notification.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The business and care manager is an experienced registered nurse who has worked in management roles in the aged care sector for many years. The business and care manager was appointed to their current position in May 2013. The business and care manager completed the National Diploma in Business.</p> <p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the business and care manager (BCM) and/or the clinical manager (CM) be absent. The CM or the clinical quality manager stands in when the business and care manager is absent. Support is also provided by the regional operations manager and the senior clinical quality manager from the support office. The CM confirmed their responsibility and authority for this role.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality improvement plan with quality objectives, including a quality and risk management plan and business plan were reviewed. These are used to guide the quality programme and include goals and objectives. Completed internal audits for 2015/2016 were reviewed. Family, resident and staff satisfaction surveys are completed as part of the audit programme and collated results for surveys were reviewed.</p> <p>Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes</p>

		<p>relevant policies and procedures. Monthly quality meetings are held. Resident meetings are held every month. Meeting minutes reviewed provided evidence of reporting/feedback on completion of internal audits and various clinical indicators.</p> <p>Clinical indicators and quality improvement data is recorded and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed, evaluated and reported. There was evidence this information is being reported to staff at staff meetings.</p> <p>Quality improvement data reviewed, including meeting minutes provided evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed. Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are available with systems in place for reviewing and updating the policies and procedures regularly, including a policy for document update reviews and document control policy. Staff confirmed during interviews that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>FA</p>	<p>Staff document adverse, unplanned or untoward events on an accident/incident form. Families are being informed after adverse events, confirmed in clinical records and during family and resident interviews. Accident and incident forms are reviewed and signed off by the business and care manager. Corrective action plans address areas requiring improvement and were documented.</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions and policies and procedures. Policy and procedures comply with essential notification reporting for example; health and safety, human resources, infection control.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checking, criminal vetting, completed orientations and competency assessments.</p> <p>Copies of annual practising certificates were reviewed for all staff that require them to practice and are current. The clinical manager is responsible for the in-service education</p>

		<p>programme. Competency assessment questionnaires were available and completed competencies were reviewed. All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are supported to complete education via external education providers. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The business and care manager advised that staff are orientated at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. This is organisational practice. Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed an orientation, including competency assessments.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided 24 hours a day. On call after hours RN support and advice is provided by the clinical manager. The minimum amount of staff on duty is during the night and consists of on-call RN support and three caregivers on-site.</p> <p>Care staff interviewed reported there are adequate staff available and that they are able to get through their work. There is at least one staff member with a current first aid certificate on each shift. Residents and family interviewed reported staff provide them with adequate care.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Resident information was entered in an accurate and timely manner into a register on the day of admission, using the 'Peoples Point' system. Resident files are integrated and recent resident information was located in residents' files. Resident files reviewed provided evidence that an entry into the residents' clinical record includes the time of entry, the date, and entries are dated. Approved abbreviations are listed.</p> <p>Residents' information is stored securely in staff areas. Clinical notes are current and accessible to all clinical staff. Individual resident files demonstrated service integration. This included medical care interventions. Medication charts are in a separate folder with medication. The resident's national health index (NHI) number, name, date of birth and GP are used as the unique identifier. Clinical staff interviewed confirm they know how to</p>

		maintain confidentiality of resident information.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Entry and assessment processes are recorded and implemented. The service's philosophy is displayed at the facility and communicated to residents, family, relevant agencies and staff. The facility information pack is available for residents and their family and contains all relevant information. The information pack contains information on the practices particular to the dementia unit.</p> <p>The residents' admission agreements evidence resident and/or family and facility representative sign off. The admission agreement defines the scope of the service and includes all contractual requirements. Residents' needs assessments are completed for rest home and dementia level of care. In interviews, residents and family confirmed the admission process was completed by staff in a timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care was conducted.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is appropriate communication between families and other providers, that demonstrate transition, exit, discharge or transfer plans are communicated, when required.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management policy is comprehensive and identifies all aspects of medicine management.</p> <p>Medications, including controlled drug storage, evidence a dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. However, the medication room in the rest home requires safety strategies to be implemented. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded.</p> <p>All staff authorised to administer medicines have current competencies. The medication rounds were observed and evidenced the staff members were knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.</p>

		<p>Medicine charts evidence residents' photo identification, legibility, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. The residents' medicine charts record all medications a resident is taking (including name, dose, frequency and route to be given). As required medicines (PRN) need to be prescribed correctly.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>There were no residents self-administering medicines at the facility on audit days. Policy on self-administration of medication is recorded.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service policies and procedures are appropriate to the service setting with a seasonal menu reviewed by a dietitian.</p> <p>In interview, the chef confirmed they are aware of the residents' individual dietary needs. The residents' dietary requirements are identified, documented and reviewed on a regular basis. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the chef. Kitchen staff have completed food safety training.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service, reported their individual preferences are met and adequate food and fluids are provided. Evidence of resident satisfaction with meals was also verified in the resident satisfaction surveys and resident meeting minutes. Additional snacks/food and drinks are available over a 24 hour period for residents with dementia.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation,</p>	FA	<p>The business and care manager stated that a process to inform residents and family, in an appropriate manner, of the reasons why the service had been declined would be implemented, if required. The residents would be declined entry if not within the scope of the service or if a bed was not available.</p>

where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>On admission, the residents have their needs identified through a variety of information sources that include: the needs assessment and service coordination (NASC) agency; other service providers involved with the resident; the resident; family/whānau; GP; specialist and on-site assessments using a range of assessment tools. The information gathered by the RN is documented and informs the initial care planning process. The residents' needs, outcomes and goals are identified via the assessment process and recorded. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.</p> <p>Over the three weeks post admission, the RN undertakes an interRAI assessment, however these have not always been completed. The long term care plan is completed within the required three weeks' timeframes post admission</p> <p>The residents' files evidence residents' discharge/transfer information from the district health board (DHB), where required. The facility has appropriate resources and equipment, confirmed at staff interviews. Assessments are conducted in a safe and appropriate setting including visits from the doctor. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The residents' care plans are individualised, integrated and up to date. The care plan interventions reflect the risk assessments and the level of care required. Short term care plans are developed, when required and signed off by the RN when problems are resolved. In interviews, staff reported they receive adequate information for continuity of residents' care. The residents have input into their care planning and review. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interview.</p> <p>The residents' with dementia have care plans that record specific behavioural management strategies based on assessment and prevention, and management of behaviour over a 24 hour period.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate</p>	FA	<p>The residents' care plans evidence detailed interventions based on assessed needs, desired outcomes, or goals of the residents. The GP documentation and records are current. In interviews, residents and family confirmed their and their relatives' current care</p>

<p>services in order to meet their assessed needs and desired outcomes.</p>		<p>and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the residents they were allocated to care for.</p> <p>The facility has sufficient supplies of equipment that comply with best practice guidelines and meet residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>FA</p>	<p>Residents are assessed on admission to determine their appropriate individual diversional, motivational and recreational requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents and provided seven days a week. In interview, the diversional therapist (DT) confirmed the activities programme meets the needs of the service group and the service has appropriate equipment.</p> <p>The activities staff plan, implement and evaluate the activities program. Along with the activities staff, the health care assistants in the dementia unit implement individual resident's activities, as recorded on the residents' 24 hour activities care plans. Interviews with health care assistants confirmed this.</p> <p>Regular exercises and outings are provided for those residents able to partake. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. There are current, individualised activities care plans in residents' files. The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programme. Family meetings are held at the facility and family interviews confirmed attendance.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Time frames in relation to care planning evaluations are documented.</p> <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the CM or the RN. The residents' care plans are up-to-date and reviewed six monthly. There is evidence of resident, family, health care assistants, activities staff and GP input in care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <p>When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans are in some of the residents' files, used when required. Short term</p>

		<p>care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. The family are notified of any changes in resident's condition, confirmed at family interviews.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Appropriate processes are in place to provide choices for residents in accessing or referring to other health and/or disability services. Family communication sheets confirm family involvement. An effective multidisciplinary team approach is maintained and progress notes detail relevant processes are implemented.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and the hazard register is current. 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. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There is provision and availability of personal protective clothing and equipment including; goggles/visors; gloves; aprons; footwear; and masks. During a tour of the facility, personal protective clothing and equipment was observed in areas where there were risks.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed; the date of expiry is 23 December 2016. There have been no building modifications since the last audit. The service has a planned maintenance schedule implemented with an annual test and tag programme and this is up to date with checking and calibrating of clinical equipment annually.</p> <p>Interviews with staff and observation of the facility confirm there is adequate equipment including; pressure relieving mattresses; shower chairs; hoists and sensor alarm mats.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet, providing privacy when required. There are internal courtyards and grass areas with shade, seating and outdoor tables. The service has a secure unit for residents identified as requiring dementia care. This area has swipe card access internally and exits into a secure</p>

		courtyard; garden and grass area which includes shade and seating.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>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.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members report that there are sufficient toilets and showers, with some rooms in the rest home/hospital area having their own en-suite. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to safely move around within the room. Equipment is sighted in rooms requiring this with sufficient space for both the equipment, for example; hoists, at least two staff and the resident. Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own.</p> <p>There is room to store mobility aids, such as walking frames, in the bedroom, safely, during the day and night, if required.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has lounge and 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, when required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>The dining areas have ample space for residents. Residents can choose to have their meals in their room.</p> <p>The dementia unit has its own dining room and lounge area with activities held in this area. Residents from the dementia unit are encouraged to join in with activities held in the main rest home area, as observed during the audit.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry services are completed at another Oceania service provider and delivered to the facility in covered laundry trolleys and bags. 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.</p> <p>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. Cleaners were observed on the days of the audit, particularly in the dementia unit, and they kept the trolley in sight.</p> <p>All chemicals are in appropriately labelled containers. Laundry chemicals are administered through a closed system which is managed by a chemical contractor company. 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.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>An evacuation plan was approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff six monthly, the most recent drill took place at the end of September 2015. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. All required fire equipment is sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>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.</p> <p>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. There is always at least one staff member with a first aid certificate on duty, with twenty care staff having completed first aid training.</p> <p>The doors are locked in the evenings. Staff complete a check in the evening that confirmed that security measures had been put in place.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever possible. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area for residents.</p> <p>Family and residents confirm that rooms are maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>FA</p>	<p>The infection control (IC) policy and procedures provide information and resources to inform staff on infection prevention and control.</p> <p>The delegation of IC matters is documented in policies, along with an infection control nurse's (ICN) job description. The ICN is a RN. There is evidence of regular reports on infection related issues and these are communicated to staff and management.</p> <p>There is a companywide Oceania IC committee, which is led by the Oceania general manager, aged care. The IC programme is reviewed annually by the Oceania IC committee with input from personnel deemed necessary.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICN has access to relevant and current information, which is appropriate to the size and complexity of the service, including but not limited to: IC manual; internet; access to experts; and education. In interview, the ICN stated they attend infection prevention and control information support group at Hawke's Bay DHB (HBDHB) bi-monthly. This group's purpose is to extend and improve communication, knowledge and management of IC issues. Interview with the ICN confirms close working relationships with the HBDHB infection prevention and control specialists.</p> <p>The IC team at the facility consists of representatives from all service areas within the facility. IC is an agenda item at the facility's meetings, evidenced during review of meeting minutes and interviews with staff.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily</p>	<p>FA</p>	<p>The IC policies and procedures are reviewed by the company wide Oceania IC committee and are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interviews. IC policies and procedures identify links to other documentation in the facility</p>

<p>available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>IC education is provided to all staff, as part of their orientation and as part of the on going in service education programme. In interviews, staff advised that clinical staff identify situations where IC education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted. This was confirmed by the ICN. The IC staff education is provided by the ICN and by self-directed learning. Education sessions have evidence of staff attendance/participation and content of the presentations. Staff are required to complete IC competencies, sighted in staff files and confirmed at staff interviews. ICN has conducted external IC education in 2015.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The ICN is responsible for the surveillance programme. The surveillance programme monitors the numbers and types of infections occurring at the facility. The surveillance data is used for benchmarking against other Oceania facilities. Monthly surveillance analysis is completed and reported at monthly general staff meetings.</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short term care plans.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interview, the ICN confirmed no outbreak occurred at the facility since last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enabler is congruent with the definition in the standard. There were no residents at the facility using enablers or residents using restraint on audit days.</p> <p>The approval process for enabler use would be activated when a resident voluntarily</p>

		<p>requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.</p> <p>In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training was provided. The staff restraint competencies are current.</p>
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## 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)
<p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Low	Two of four residents files reviewed in the dementia unit had end of life care consents in place for the residents.	Two of four directives for 'not for resuscitation' in the dementia unit were signed by the enduring power of attorney (EPOA) and the GP signed not to provide treatment.	<p>The service to demonstrate appropriate consents are obtained.</p> <p>30 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and</p>	PA Moderate	The medication trolley in the dementia unit is locked and stored in the dementia lounge. The rest home medication room has an external hook to lock the room and this	i) The medication room in the rest home has an external hook	<p>Provide evidence:</p> <p>i) Medication</p>

<p>appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>requires an improvement. The medication within the room is locked in cupboards, however the fridge medication can be accessed.</p> <p>Staff state that medication is checked upon arrival at the facility, however there is no recorded evidence of this being conducted.</p> <p>Medication files reviewed evidenced the as required (PRN) medications are not consistently or correctly prescribed. There were seven of twenty medication charts that did not have either maximum doses or indications of use recorded.</p>	<p>on the door used as a locking device.</p> <p>ii) The medication is checked on arrival at the facility, however there are no records of this maintained.</p> <p>iii) As required medication (PRN) are not consistently prescribed, as required.</p>	<p>room in the rest home is only accessed by authorised personnel</p> <p>ii) Medications are checked upon arrival to the facility and a record of this is maintained.</p> <p>iii) PRN medication is prescribed correctly.</p> <p>90 days</p>
<p>Criterion 1.3.4.2</p> <p>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.</p>	<p>PA Low</p>	<p>InterRAI assessments are not consistently completed. Six of seven interRAI assessments had not been completed, when required. Seven of the eight charts reviewed required interRAI assessments to be completed . The RN stated the interRAI assessments are completed when residents care needs level alters and this was evidenced in the files of residents that required dementia care from rest home level of care.</p>	<p>The interRAI assessments are not being completed as required.</p>	<p>Provide evidence the interRAI assessments are completed</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.