

Oceania Care Company Limited - Greenvalley

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: Greenvalley

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

Dates of audit: Start date: 26 September 2017 End date: 27 September 2017

Proposed changes to current services (if any): The service requested a reconfiguration of service to increase the number of beds from 30 to 32 in the rest home, changing the total bed capacity from 50 to 52 beds at the facility.

Total beds occupied across all premises included in the audit on the first day of the audit: 48

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

Greenvalley Lodge (Oceania Healthcare Limited) can provide care for up to 50 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. Occupancy on the day of the audit was 48. The service provides rest home and dementia care.

The audit process included the review of policies and procedures, the review of resident and staff files, and observations and interviews with residents, family, management, staff and a general practitioner.

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

There has been a request for increase of beds from 30 to 32 in the rest home, to facilitate couples sharing rooms. This increases the total capacity of Greenvalley Lodge to 52 beds.

There is a requirement for improvement relating to risk assessments.

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.		Standards applicable to this service fully attained.
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Services are provided in a manner that considers the dignity, privacy and independence of residents. Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is 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 the residents' needs and communication is appropriate.

Staff confirmed an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and during caring for the residents. The residents' cultural and spiritual needs, and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices in relation to the care they receive.

The business and care manager is responsible for the management of complaints. Residents and families interviewed confirmed they are informed of the process to make a complaint.

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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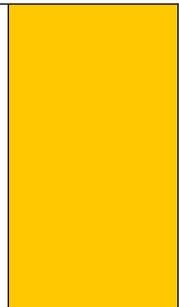
Oceania Healthcare Limited is the governing body for Greenvalley Lodge and is responsible for the services provided. The business and care manager is qualified for the role.

The service uses a documented quality and risk management system that supports the business management and provision of clinical care. Quality and risk performance is reported through meetings at the facility and is monitored by the organisation's management team through the business status reports and regional operations manager reports.

Quality improvement is monitored and benchmarking reports include incident/accidents, infection, complaints and clinical indicators with trends analysed to improve service delivery. Incidents and accidents are investigated using a root cause analysis methodology and open disclosure to residents and their families is practised.

The organisation has systems in place to manage and predict staffing levels. Human resource policies and processes are aligned with good employment practice and legislation. Orientation, ongoing learning and development opportunities are available for staff. Resident information is identifiable, accurately recorded, current, confidential, accessible when required and securely stored.

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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The residents' needs are assessed on admission by registered nurses. The residents' files provided evidence the resident's needs, goals and outcomes are documented and reviewed on a regular basis. The residents and families interviewed reported being informed and involved and that the care provided is of a high standard.

The activities programmes include a wide range of activities, involvement with the wider community and incorporate the residents' past and present interests. The dementia unit activities programme is documented for the activities staff to implement from Monday to Friday. The after-hours and weekend activities programme for the dementia unit is implemented by healthcare assistants.

There is an appropriate medicine management system in place. The staff responsible for medicine management attend medication management in-service education and have current medication competencies. The residents self-administering medicines do so according to policy.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines. The food service meets residents' special dietary requirements. Residents have a role in menu choice and interviews with residents verified satisfaction with meals provided.

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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Greenvally Lodge has systems to ensure the environment for patients, staff and visitors is appropriate and safe. There is a cleaning schedule and cleaning staff are trained. Waste is disposed of according to policy and legislative requirements. Staff are educated to handle waste safely. Hazardous substances and chemicals are stored and registered appropriately.

The facility has a current building warrant of fitness and a preventative maintenance programme to ensure the building, utilities and equipment comply with the regulations and safety requirements.

Residents' rooms, in both the rest home and the dementia unit, are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. The two reconfigured rooms in the rest home to accommodate couples are spacious and can facilitate this. Previously these rooms had been used for couples who chose to share a room and had been converted to single room use. These rooms are suitable as double rooms and with the use of curtains maintain privacy whenever required.

The organisation has developed and maintained plans to respond to emergency situations, including fire and medical emergencies. Exercises for disaster response and evacuation of buildings are held and staff are trained. There is emergency equipment and supplies available on site in the event of an emergency. Laundry services are contracted out.

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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The service has documented policies and procedures for restraint minimisation and safe practice. Restraint minimisation and safe practice is part of the orientation of new staff and ongoing mandatory education in restraint minimisation is provided. Management and staff interviews confirmed their knowledge of the standard and the use of alternative techniques to restraint, including de-escalation techniques.

There were no residents using restraints or enablers on audit days. The restraint/enabler register evidenced that restraint has not been used at the facility in 2017. All residents in the dementia unit have 24-hour challenging behaviour management plans to ensure their behaviour is managed in an appropriate manner.

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. New employees are provided with training in infection prevention and control practices and there is ongoing infection control education available for all staff.

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

The infection control surveillance data confirmed that the surveillance programme is appropriate for the size and complexity of the services provided.

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	44	0	0	1	0	0
Criteria	0	92	0	0	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Greenvally Lodge is guided by Oceania Healthcare Limited's overarching policies, procedures and processes to meet its obligations in relation to the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code).</p> <p>Interviews with staff demonstrated knowledge and understanding of the requirements of the Code. Staff were observed demonstrating respectful communication, open disclosure, encouragement of patient independence, provision of options and maintenance of residents' dignity and privacy.</p> <p>The Code is a component of the staff induction process and the education planner reviewed evidenced ongoing education on the Code is provided.</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</p>	FA	<p>There is an informed consent policy and procedure that directs staff in relation to informed consent processes. Staff ensure that all residents are aware of treatment and planned interventions. The resident and/or family are included in the planning of care. Resident files identified informed consent is obtained. Interviews with staff confirmed their understanding of informed consent processes.</p> <p>Service information packs include information regarding informed consent. The BCM and CM discuss informed consent processes with residents and their families during the admission process. The policy and procedure includes guidelines for consent for resuscitation/advance directives and resuscitation orders are</p>

choices and give informed consent.		completed for residents when applicable.
<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>Information relating to advocacy services is available at the facility and in information packs provided to residents and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Staff training regarding advocacy services is provided annually. Family and residents confirmed that the service provides opportunities for the family/EPOA to be involved in decisions and they stated they had been informed about advocacy services.</p> <p>Residents are encouraged to have support people of their choice with them when information is being provided. Resident interviews confirmed that they were aware of advocates and how they could access an advocate or a support person.</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>The service has an open visiting policy and 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 confirmed they could visit at any time and are always made to feel welcome.</p> <p>Residents are encouraged to be involved in community activities and to maintain family and friend networks. 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 organisation's complaints policy and procedures are in line with the Code and include timeframes for responding to a complaint. Complaint forms are available at the facility. The complaints processes are in line with legislative requirements. 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. Review indicated that complaints are investigated promptly and issues are resolved in a timely manner. Staff, residents and family confirmed they knew the complaints process.</p> <p>The BCM is responsible for managing complaints. Residents and family stated complaints are dealt with as soon as they are identified. There have been no complaints with external agencies.</p>
Standard 1.1.2: Consumer Rights During Service Delivery	FA	The Code is displayed in the service in poster form and pamphlets are readily available. Information about the Code is provided in all new residents' information packs. The business and care manager (BCM) and the clinical manager (CM) discuss the Code with residents and their family on admission. Discussion

<p>Consumers are informed of their rights.</p>		<p>relating to the Code is also included on the agenda and discussed at the residents' meetings.</p> <p>The interviews with residents and family confirmed their rights are being upheld by the service. Information on the Code is provided to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private.</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>	<p>FA</p>	<p>The service promotes dignity, respect and quality of life. The service ensures that each resident has the right to privacy and dignity. The residents' personal belongings are used to individualise their rooms.</p> <p>There are areas where residents can have private conversations and patient information was observed to be away from public view. The residents/family confirmed their physical privacy and their dignity is maintained. Policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate manner, with strategies documented to manage any inappropriate behaviour. Healthcare assistants (HCA) were observed knocking on bedroom doors prior to entering and doors were closed when cares were being given.</p> <p>Interviews and review of the complaints register confirmed there are no concerns for any abuse and neglect in the service. Staff receive annual training on abuse and neglect and can describe signs. Staff interviewed were aware of the need to ensure residents are not exploited, neglected or abused. Staff can describe the process for escalating any issues. Staff are clear about professional boundaries and ethics that inform their behaviour when interacting with residents.</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>	<p>FA</p>	<p>The Māori health plan provides a holistic view of Māori health and how to incorporate services for Māori into the delivery of services. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. Access to Māori support and advocacy services is available, if required, from a local provider of health and social services. Cultural celebrations are included in the activities plan.</p> <p>Staff members provide cultural advice and support for residents and staff, when 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.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values,</p>	<p>FA</p>	<p>The service has appropriate policies and procedures to ensure the recognition of Māori values and beliefs and that of other cultures. Residents/family confirmed they were consulted on their individual ethnicity, culture, values and beliefs and staff respected these.</p>

<p>And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>Residents' personal preferences, required interventions and special needs were included in the care plans reviewed. Staff are educated as part of the mandatory education provided on cultural safety and cultural appropriateness. Chaplaincy service is offered to residents and their families as needed or requested.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The facility implements the Oceania Healthcare Limited (Oceania) policies and procedures based on good practice, current legislation and guidelines. Staff confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation.</p> <p>The service has clear expectations around staff conduct which is clearly communicated to staff during the employment process, orientation/induction and ongoing education. Staff training includes discussion of the staff code of conduct and prevention of inappropriate care. The staff are aware of the need to ensure unbiased fair care and treatment is provided regardless of the age, gender, religion, sexual preferences, ethnicity and/or social standing.</p> <p>Allied medical and other health professionals abide by the regulatory bodies to which they belong. There were no complaints recorded in the complaints register for the previous 12 months relating any form of discrimination.</p> <p>Job descriptions include the responsibilities of position, including ethical issues relevant to the role. Staff orientation and induction includes recognition of discrimination, abuse and neglect. Staff confirmed their understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service implements Oceania policies to guide practice. The policies align with the Health and Disability Services Standards.</p> <p>The organisation's quality framework includes their internal audit programme. Benchmarking occurs across all the Oceania facilities. There is an internal mandatory training programme for all staff and managers are encouraged to complete management training. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice and evidence-based practice.</p> <p>Interviews with residents and families expressed a high level of satisfaction with the care delivered.</p>
<p>Standard 1.1.9:</p>	<p>FA</p>	<p>Interviews with residents, representatives and/or family members confirmed they are kept informed about</p>

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>any changes to their own/the resident's health status, and are notified in a timely manner of the results of any investigations and/or treatment outcomes. This was supported in the resident's records reviewed. There was evidence of resident/family input into the care planning process.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services are accessible to staff for residents. Staff demonstrated an understanding of how to access interpreter services as required.</p>
<p>Standard 1.2.1: Governance</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 (Oceania) vision, values, mission statement and philosophy are displayed in the facility. There are systems in place recording the scope, direction and goals of the organisation.</p> <p>The BCM has been in a management role with Oceania for six years and in this role at Greenvally Lodge for one year. The BCM has 22 years' experience in aged residential care. Part of the role of the BCM is to provide monthly status reports to the support office, including data on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes and clinical indicators.</p> <p>The BCM is supported by the CM, registered nurses (RN), the regional clinical quality manager (CQM) and operations manager. The CM appointment is full-time and is responsible for all clinical matters. The CM has been in this position for two years, initially as acting CM and then as CM. The CM has been in aged residential care for around eight and a half years in New Zealand, prior to this they worked in an acute setting abroad.</p> <p>The facility can provide care for residents requiring rest home or dementia level of care. Occupancy during the onsite audit was 48 residents. On the first day of audit there were 28 residents requiring rest home level care and 20 residents in the dementia unit. The service is contracted to deliver rest home and dementia care. The service does not hold other contracts.</p> <p>There are two rooms in the rest home previously used for accommodating couples. In 2013 the service changed these rooms to being used only for single residents. The organisation now requested reconfiguration of the rooms to be used for couples again, therefore increasing the bed capacity by two in the rest home.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the</p>	<p>FA</p>	<p>The service has appropriate systems in place to ensure the day-to-day operation should the BCM be absent. The CM assumes the role and is supported by the clinical quality manager (CQM), the regional operations manager and support office.</p> <p>During absence of the CM, the senior RN with the support of the CQM, stand in.</p>

<p>service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</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>Greenvalley Lodge uses the Oceania quality and risk management framework that is documented to guide practice. The service implements organisational policies and procedures to support service delivery. Policies are subject to reviews as required, with all policies are current. The support office reviews all policies, with input from business and care managers. Policies are linked to the Health and Disability Services Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are accessible to staff.</p> <p>New and revised policies are presented to staff. Staff interviewed stated they read any new or revised policies and sign a form to indicate that they have read and understood policies.</p> <p>Clinical staff interviewed reported they are kept informed of quality improvements. There are monthly staff, quality improvement, RN and infection control meetings. Restraint meetings are held bi-monthly. The senior management meetings are held at weekly intervals. There are monthly resident meetings with family able to attend if they choose to. The meetings have agendas and corrective action timeframes completion dates and sign off are recorded.</p> <p>Service delivery is monitored through review of complaints, incidents and accidents with monthly analysis of data, surveillance of infections, and implementation of the internal audit programme. Corrective action plans are documented and evidence of resolution of issues are documented when these are identified.</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. Resident/family satisfaction surveys are completed six monthly. Results from the 2017 survey indicated that residents and family are satisfied with the service.</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</p>	<p>FA</p>	<p>Adverse, unplanned or untoward events are recorded on an accident/incident form. Staff inform families after adverse events. This was confirmed in clinical records and during family and resident interviews. Accident/incident forms are reviewed and signed off by the BCM. Corrective action plans are documented and address areas requiring improvement. There is an open disclosure policy.</p> <p>Staff confirmed that they are made aware of their responsibilities for completion of adverse events through job descriptions, and policies and procedures. Staff interviews confirmed they are made aware of their responsibilities relating to essential notification. Policy and procedures meet the terms of essential</p>

<p>where appropriate their family/whānau of choice in an open manner.</p>		<p>notification reporting for example: health and safety; human resources and infection control. The change of the CM has been reported to HealthCERT.</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 outlines accountability, responsibilities and authority. These are reviewed on staff files along with employment agreements, reference checking, criminal vetting, drug testing, completed orientations and competency assessments.</p> <p>Annual practising certificates are reviewed for all staff that require them to practice and are current. The CM is responsible for the in-service education programme. Competency assessment questionnaires are available and completed competencies were reviewed. 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. The service maintains evidence of allied health and contractors requiring annual practising certificates.</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 BCM advised that staff complete orientation and induction at employment and this was verified during the staff file reviews. 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. Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed an orientation, including competency assessments. Staff working in the dementia unit completed appropriate dementia care training as required by the contractual agreement with the district health board (DHB).</p> <p>The service has four RNs, including the CM and BCM, who have completed interRAI training.</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>	<p>FA</p>	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. There is RN cover in the mornings only; Monday to Sunday, with the CM on duty Monday to Friday and the BCM on-site two days per week, eight hours per day. The BCM also manages a second facility and spends the other three days at the second facility.</p> <p>Rosters show that where staff have been absent, the RN's adjusted staffing levels with replacements of staff at every shift where there has been an absence. Registered nurses cannot adjust staffing levels due to acuity of care, this is a decision that is made by the BCVM, the Quality Manager or the Regional Operations Manager.</p> <p>On call services after hours are provided by one of the RNs and the CM on a rotational basis; one week on and one week off. The BCM is available after-hours whenever the on-call staff need</p>

		<p>help/assistance/advice.</p> <p>Care staff interviewed reported adequate staff is available and that they are able to get through their work. Residents and family interviewed report 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>Residents' information is stored securely at nurses' stations, including clinical notes which are current and accessible to clinical staff. Information containing sensitive resident information is not displayed and cannot be viewed by other residents or members of the public.</p> <p>Entries are legible, dated and signed by the relevant HCA, RN or other staff member, including designation. Approved abbreviations are listed.</p> <p>The service retains relevant and appropriate information to identify and track resident's records. There is sufficient detail in residents' files to identify residents' ongoing care, history, and activities. Documentation in individual resident files demonstrated service integration.</p> <p>The resident's national health index number, name, date of birth and general practitioner (GP) are used as the unique identifier.</p>
<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>The entry and assessment processes are recorded and implemented. The Oceania vision, mission, and values are 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 facility pack for the prospective residents with dementia and their families contains additional information that is required under the aged residential care contract. Prospective residents and/or their families are encouraged to visit the facility prior to their admission to the facility. Records reviewed contained completed demographic details, assessments, copy of any EPOA documents, ethnicities and signed admission agreements in accordance with contractual requirements. The admission agreement defines the scope of the service and includes all contractual requirements. The 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 timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a</p>	FA	<p>Staff interviews and documentation reviewed demonstrates that families and other providers are involved with transition, exit, discharge or transfer plans. There is open communication between the service, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the residents'</p>

planned and coordinated transition, exit, discharge, or transfer from services.		files.
<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>	FA	<p>Medication areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The drug register is maintained and evidenced weekly checks and six-monthly physical stocktakes. 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>The computerised medication management system is in line with current legislative requirements and safe practice guidelines. There were two residents self-administering medicines at the facility and this was completed according to policy.</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 cook confirmed they were 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, as confirmed during the interview with the cook.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, and reported their individual preferences were met and adequate food and fluids were provided.</p> <p>The food temperatures are recorded as are the fridge, chiller and freezer temperatures. All decanted food is dated. Kitchen staff have completed food safety training.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the</p>	FA	<p>An interview with the CM verified there is a process for informing residents, their family/whānau and their referrers if entry is declined. The reason for declining entry is communicated to the referrer, resident and their family or advocate in a timely manner that is understood by those to whom the information is given. Where requested, assistance would be given to provide the resident and their family with other options for</p>

immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		alternative healthcare arrangements or residential services.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The residents' needs, outcomes and goals are identified via the assessment process and recorded (refer to 1.3.3.3). The facility has processes in place to seek information from a range of sources, for example: family; GP; specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery. The residents' files evidenced residents' discharge/transfer information from the DHB, where required. The 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.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	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. The 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 to ensure continuity of residents' care. Regular GP care is implemented. This was evidenced in current GP progress reports and confirmed at GP interview.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The residents' care plans evidence interventions based on assessed needs, desired outcomes or goals of the residents (refer to 1.3.3.3). Review of resident files demonstrated that the GP documentation and records are current. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. The nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	FA	Interviews with the DT and the activities coordinator (AC) confirmed the activities programmes meet the needs of the service group and the service has appropriate equipment. The DT and the AC plan, implement and evaluate the activities programmes. There are three activities programmes at the facility, one for the rest home, one for the dementia unit and an after-hours activities programme for the dementia unit.

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>The dementia unit activities programme is documented for the activities staff to implement from Monday to Friday. The DT and the AC share the activities in both the rest home and the dementia unit. There is evidence of planned activities provided that include the residents' past and present interests. The after-hours and weekend activities programme for the dementia unit is implemented by HCAs. The residents' participation is recorded by the HCA and reviewed by the DT. Interviews with HCAs confirmed this. There is a sensory room for the residents to use in the dementia unit and staff reported that many residents use this room.</p> <p>All residents have activities progress notes that are completed by the activities staff and summarise the activities participation on a monthly basis.</p> <p>There are current, individualised activities care plans in residents' files. The residents' activities attendance records are maintained. The residents' meeting minutes evidence residents' involvement and consultation in the planned activities programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Timeframes in relation to care planning evaluations are documented. The residents' care plans are up to date and reviewed six-monthly. There is evidence of resident, family, HCAs, activities staff and GP input into the multidisciplinary reviews. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <p>The residents' progress records are entered on each shift. When resident's progress is different than expected, the RN contacts the GP as required. Short-term care plans were in resident's files where required. The family are notified of any changes in resident's condition and this was 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) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet</p>	<p>FA</p>	<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 confirmed family involvement. An effective multidisciplinary team approach is maintained and progress notes detail that relevant processes are implemented.</p> <p>If the need for non-urgent external services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process. This was verified in the review of documentation and in interviews. Acute/urgent referrals are attended to immediately and the</p>

consumer choice/needs.		resident is sent to accident and emergency in an ambulance if the circumstances dictate.
<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>The service has documented processes for the management of waste and hazardous substances in place. The hazard register is current. Policies and procedures for chemicals specify labelling requirements which are in line with legislation, including the requirement for labels to be clear and free from damage.</p> <p>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, confirmed during interviews with staff.</p> <p>There is provision and availability of personal protective clothing and equipment including: goggles; gloves; aprons; footwear; and masks. During a tour of the facility, personal protective clothing and equipment was observed in areas where there are 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 service has a planned maintenance schedule implemented with a test and tag programme. Checking and calibration of clinical equipment is completed annually by a contractor.</p> <p>There have been no building modifications since the last audit. Interviews with staff and observation of the facility confirmed there is adequate equipment to meet the needs of residents.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet in private, should this be required. There are external areas with shade and outdoor furniture. There are ramps and rails at entrance doors for access for residents. Residents in the dementia unit have a secure garden with pathways, appropriate seating, shade and areas that are of interest to them; for example, raised gardens.</p> <p>The service submitted an application to have two rest home rooms approved for use by couples. These rooms were previously (prior to 2013) used by the service to accommodate couples. The rooms are spacious and allows for aids to be used freely around resident beds. The rooms have full en-suites. Both rooms have calls bells for two people and there are curtains to ensure privacy at all times. These rooms are suitable for accommodating couples.</p> <p>The corridors promote safe mobility, use of aids and independence. The service has wall mounted hand gels throughout the corridor, promoting hand hygiene between rooms.</p>
Standard 1.4.3: Toilet,	FA	There are adequate numbers of accessible toilets/bathing facilities in the dementia unit and all residents in the rest home have en-suite facilities. Visitors' toilets and residents' toilets are located close to communal

<p>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>		<p>areas. All the toilets have a system that indicates if it is engaged or vacant.</p> <p>All the residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence.</p> <p>Residents and family members reported 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.</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 in all the bedrooms to allow residents and staff to safely move around in the room, including the rooms which are assessed for use by couples.</p> <p>Equipment was sighted in rest home rooms, with sufficient space for the equipment, staff and the resident, for example; wheel chairs. The residents' rooms are personalised with furnishings, photos and other personal possessions. Residents and families are encouraged to personalise their rooms.</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 lounges and dining areas including areas that can be used for activities. All communal areas are easily accessed by residents and staff. Residents are able to access areas for privacy, when required. Activities are carried out in one of the two lounge areas in the dementia unit.</p> <p>Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely. There is furniture in the garden areas and designated parking spaces for the mobility scooters.</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>	FA	<p>All laundry services are completed off-site. Linen and other laundry is sent to another Oceania facility for laundry services. Linen trolleys are used for removal of dirty laundry. Staff receive clean laundry, sort it and deliver the clean laundry to residents' rooms. 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. Cleaners have a lockable cupboard to store 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 keeping the cleaning trolley in sight. Chemicals are in appropriately labelled containers.</p> <p>Laundry chemicals are administered through a closed system which is managed by a chemical contractor</p>

		company. Products are used with training around use of products provided.
<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>	FA	<p>The evacuation plan has been approved by the New Zealand Fire Service. The service has an evacuation policy on emergency and security situations is in place. Fire drills are completed six-monthly. The orientation programme includes fire and security training. Checking the fire exits daily for clearance is on the maintenance daily schedule. Staff confirmed their awareness of emergency procedures. Fire equipment was 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. An escalating electronic call bell system is utilised. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways, dining rooms. Call bell audits are routinely completed and residents and family stated there are prompt responses to call bells.</p> <p>External doors leading to the gardens are locked after sunset, these doors can only be opened from the inside. Afternoon staff complete a security check of all external doors in the evening to confirm security measures are 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>	FA	<p>The service has procedures in place to ensure they are 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.</p> <p>Monthly room temperature checks are monitored. There is a designated external smoking area for residents, however, there are currently no smokers at the facility. Family and residents stated that the building is maintained at an appropriate temperature in both winter and summer.</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</p>	FA	<p>The infection control policy and procedures manual provides information and resources to inform staff on infection prevention and control.</p> <p>The delegation of infection control matters is documented in policies, along with the infection control nurse's (ICN) job description. The ICN is the clinical manager/registered nurse and is supported in their role by the BCM and the infection control team. There is evidence of regular reports on infection related issues and these are communicated to staff and management.</p> <p>The Oceania infection control programme is reviewed annually by the Oceania infection control committee (company-wide). The facility's infection control programme is reviewed by the infection control team at the</p>

scope of the service.		facility.
<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>	FA	<p>The ICN has access to relevant and current information which is appropriate to the size and complexity of this service and takes the leadership role in the infection control team. Infection control is an agenda item at the facility's meetings, evidenced during review of meeting minutes and interviews with staff.</p> <p>The internal audit programme includes infection control audits to monitor the implementation of the infection control programme. The infection control internal audits are reported on at the facility's meetings.</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 available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The Oceania infection control committee (company-wide) develop and review the infection control policies and procedures to be implemented within the Oceania facilities. There is evidence the policies and procedures are up to date, reflect current accepted good practice and relevant legislative requirements. Staff interviews confirmed the infection control manual is readily accessible to all personnel.</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>	FA	<p>The infection control programme is introduced to all new employees as part of the orientation process and includes hand hygiene. The infection control education is part of the ongoing in-service education programme. There is evidence of a number of infection prevention and control education sessions in 2017. The infection control staff education is provided by the ICN, RNs and external specialists. The education sessions have evidence of staff attendance/participation and content of the presentations. Staff are required to complete infection control competencies. Competencies were sighted in staff files and confirmed at staff interviews.</p>

		In interviews, staff advised clinical staff identify situations where infection control education is required for a resident such as: hand hygiene or cough etiquette; and one on one education is conducted.
<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>	FA	<p>The ICN is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at facility's meetings and reported to the Oceania support office as a key performance indicator. All infections are entered into the clinical indicators on the Oceania intranet and reviewed by the clinical and quality team at the Oceania support office. The infection control data is reported to the Oceania board on a monthly basis.</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. The residents' files evidenced the residents' who were diagnosed with an infection had short-term care plans in place.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the CM, RNs, verbal handovers, short-term care plans and residents' 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 has 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>	FA	<p>The Oceania organisation-wide policies and procedures meet the requirements of the restraint minimisation and safe practice standards. The definitions of restraint and enabler are congruent with the definitions in the standard. The restraint coordinator is the CM, who has a position description for this role. The restraint coordinator demonstrated knowledge of the organisation's policies, procedures and practice. There is documented evidence of current restraint education and training relevant to the role of the restraint coordinator. Staff interviews confirmed their knowledge of the standard and alternative techniques to restraint, including de-escalation techniques where applicable.</p> <p>Restraint minimisation and safe practice is part of the orientation of new staff and ongoing mandatory education in restraint minimisation is provided.</p> <p>There were no residents using restraints or enablers on audit days. The restraint/enabler register evidenced restraint has not been used at the facility in 2017.</p>

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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>The initial interRAI assessments are not consistently completed within the required 21 day timeframe post residents’ admission to the facility. Interview with the Oceania CQM and review of the documentation evidenced there were 4 residents admitted to the facility in 2017 with initial interRAI assessments completed after 21 days. The reason for the late completion of the interRAI assessments was that the NASC team did not provide the assessment to the facility in a timely manner. The timeframes of these four interRAI assessments being provided to the facility from NASC ranged between four to eight weeks post admission.</p> <p>There were 3 residents who were admitted with interRAI assessments from NASC on their admission to the facility in 2017, however, the initial interRAI assessments were completed outside of the 21 day timeframe.</p> <p>The rest home tracer’s clinical file evidenced not all initial risk assessments</p>	<p>The timeframes relating to initial risk assessments and six monthly risk re-assessments are not consistently adhered to, including initial interRAI assessments.</p>	<p>Provide evidence the risk assessments are completed within the required timeframes.</p> <p>90 days</p>

		and risk reassessments are completed when required. One additional rest home file evidenced the risk re-assessments for the resident were completed post the six month timeframe.		
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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, 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

End of the report.