Oceania Care Company Limited - Otumarama Home & Hospital

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:	Otumarama Home and Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 30 July 2015 End date: 31 July 2015
Proposed changes to current services (if any): None	
Total beds occupied across all premises included in the audit on the first day of the audit: 37	

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

Otumarama Home and Hospital (Oceania Care Company Limited) can provide care for up to 51residents. This certification audit is conducted against the Health and Disability Service Standards and the service contract with the district health board.

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

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

Improvements are required to reporting of incidents, resident assessments, plans and evaluations.

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.

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive.

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.		Some standards applicable to this service partially attained and of low risk.

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

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

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

There is evidence that each stage of service provision is developed with resident and/or family input, within stated timeframes and coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices.

A sampling of residents' clinical files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan.

Planned activities are appropriate to the group setting. The residents' files evidenced individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management have current medication competencies. There was one resident who self-administered medicines at the facility and did so according to policy and guidelines.

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 had 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.

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

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The restraint policy, procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There were no residents using restraint on audit days. Two residents requested the use or enablers and review of their files evidenced correct processes are followed for enabler use. Staff education in restraint, de-escalation and challenging behaviour had 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.
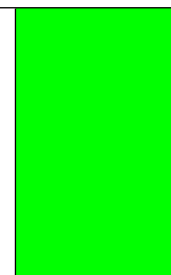
Standards applicable to this service fully attained.

The infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection and cross infection, and meet the requirements of the standard. The policies and procedures guide staff in all areas of infection control practice. New employees are provided with training in infection control practices and there is an on-going infection control education available for all staff.

Infection control is a standard agenda item at facility's meetings. Staff interviews confirmed staff are familiar with infection control measures at the facility. The information sampled confirms 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 AttainedStandards applicable to this service 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	41	0	1	3	0	0
Criteria	0	89	0	1	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. All staff have had training in 2015. Interviews with the staff confirmed their understanding of the Code. Examples are provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs. The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information. The auditors noted respectful attitudes towards residents on the day of the audit.
Standard 1.1.10: Informed Consent	FA	There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. Staff ensure that all

| Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | | residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.

All resident files identified that informed consent is collected. Interviews with staff confirmed their understanding of informed consent processes.

The service information pack included information regarding informed consent. The registered nurse or the clinical leader discusses informed consent processes with residents and their families/whānau during the admission process.

The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files noted that all had appropriately signed advanced directives. |
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| Standard 1.1.11: Advocacy And Support

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service.

Staff training on the role of advocacy services is included in training on The Code of Health and Disability Consumers' Rights – last provided for staff in 2015.

The Health and Disability Advocate visits the service as requested by the management team and/or residents.

Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources

Consumers are able to maintain links with their family/whānau and | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked or ring the doorbell to access staff. |

their community.		Families interviewed confirm they could visit at any time and are always made to feel welcome.

Residents are encouraged to be involved in community activities and to maintain family and friends networks. |
| Standard 1.1.13: Complaints Management

The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisation's complaints policy and procedures is in line with the Code and included periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved. Evidence relating to each lodged complaint is held in the complaint's folder.

Three complaints reviewed in 2015 indicate that the complaints are investigated promptly with the issues resolved in a timely manner.

Residents and family member's state that they would feel comfortable complaining. Two residents state that they have put in concerns and both state that these have been addressed.

There has been one complaint lodged with the Health and Disability Commission since the previous audit. The Health and Disability Commission has confirmed that there are no further actions required. |
| Standard 1.1.2: Consumer Rights During Service Delivery

Consumers are informed of their rights. | FA | The business and care manager, clinical leader or a registered nurse discusses the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code can also be held at the resident meeting and the Health and Disability advocate attends when requested to discuss rights as sighted in meeting minutes in 2015. Residents and family interviews confirm their rights are being upheld by the service. The information pack includes information around rights and this can be produced in a bigger font if required.

Information is given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and family members are able to describe their rights and advocacy services |

		particularly in relation to the complaints process.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Resident support needs are assessed using a holistic approach. The initial and on-going assessment gains details of people's beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated. A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident. The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings. Health care assistants report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families confirm that residents' privacy is respected. Staff report that they encourage each residents' independence. This is particularly important for residents under the age of 65 years with the service having a strong focus on rehabilitation. Residents and family all gave examples of being encouraged to be as independent as possible and cited examples of significant improvements in the resident's physical and social abilities. Three residents in the past two years have returned to independent living in the community. The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff received annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports

		for 2015 or on incidents reviewed in resident files.
		Resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service implements the Maori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan. The service has links to local kaumatua and Maori services are through the district health board. There are staff who identify as Maori and staff report that specific cultural needs are identified in the residents' care plans. There are no Maori residents currently using the service. Staff are aware of the importance of whanau in the delivery of care for the Maori residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies each resident's personal needs from the time of admission. This is achieved with the resident, family and/or their representative. There is a culture of choice with the resident determining when cares occur, times for meals and choices in meals and activities. Staff work to balance service delivery, duty of care and resident choice. Health care assistants are able to give examples of how choice is given to residents who have non-verbal ways of communicating. The service has focused on providing choices for younger residents that encourages their independence and focuses on furthering their abilities. Examples include self-serve meals, a 'common room' with additional resources (e.g. computer suite, own television and an emphasis on access to the community). Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment included the resident's cultural values and beliefs. This information is used to develop a care plan. While there is one resident who speaks English as a second language, the resident is able to make needs known. The service has attempted to

		engage the resident with a speaker of their language both for interpretation and company, however there are none known by the external multicultural council and other services contracted. The service has also tried to engage with family but have not been able to contact them. Staff have translated words in the room to help with the provision of care.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility implements the Oceania policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care. Job descriptions included responsibilities of the position, ethics, advocacy and legal issues with a job description sighted in staff files reviewed relevant to the role held by the staff member. The orientation and employee agreement provided to staff on induction included standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the health care assistants' role and responsibilities.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Otumarama Home and Hospital implements Oceania policies to guide practice. These policies aligned with the health and disability services standards and are reviewed bi-annually. A quality framework supports an internal audit programme. Benchmarking occurs across all the Oceania facilities. There is a training programme for all staff and managers are encouraged to complete management training. There are monthly regional management meetings. Specialised training and related competencies are in place for the registered nursing staff. Residents and families interviewed expressed satisfaction with the care delivered noting that some residents and family had individual issues that they wished to raise. There were no common themes identified from resident and family discussions.

		Consultation is available through the organisation's management team that included registered nurses, the regional manager and a dietitian.
		The key projects implemented in the past year included the following: a) refurbishment of bathrooms; b) development of activities and resources that focus on a rehabilitative approach to care for young residents under the age of 65 years.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Accident/incidents, the complaints procedure and the open disclosure procedure alerted staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms. Family contact is recorded in residents' files. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member and could attend the resident meetings. Interpreter services are available from the district health board. There are no residents requiring interpreting services noting that the management team have tried to access interpreting services for one resident. Residents sign an admission agreement on entry to the service. This provided clear information around what is paid for by the service and by the resident. All are signed on the day of admission.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Otumarama Home and Hospital is part of the Oceania Care Company Limited with the executive management team including the chief executive, general manager, regional manager, operations manager and clinical and quality managers providing support to the service. Communication between the service and managers takes place on at least a monthly basis with the operations manager and the clinical and quality manager providing support during the audit. The monthly

business status report provides the executive management with progress against identified indicators.

There is a clear mission, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training provided annually.

The facility can provide care for up to 51 residents with all beds identified as dual purpose beds. During the audit there were 37 residents living at the facility including 24 residents requiring rest home level of care and 13 residents requiring hospital level of care. Ten residents identify as young people with disability requiring either rest home or hospital level care.

The business and care manager is responsible for the overall management of the facility, has been in the role for four years and has over nine years' experience in aged care with experience also in rehabilitation services. The business and care manager has relevant qualifications including a diploma in business, a postgraduate certificate in assessment of the older person and is a registered nurse with a current practicing certificate.

Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the business and care manager, the clinical leader is in charge with support from the regional operations manager and clinical and quality manager (organisational). The clinical leader has been appointed into the role at the beginning of 2015 and has experience in acute care. Health CERT has been informed of the appointment of the clinical leader.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Otumarama Home and Hospital uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and

		Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to say that they have read and understood.
		Service delivery is monitored through complaints, review of incidents and accidents (refer to 1.2.4), surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed. There is documentation that includes collection, collation, identification of trends and analysis of data.
		Meeting minutes evidences communication with all staff around all aspects of quality improvement and risk management. There are also resident meetings that kept residents informed of any changes. Staff report that they are kept informed of quality improvements.
		There is an annual family and resident satisfaction survey with satisfaction documented.
		The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low	The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, sentinel events, infectious disease outbreaks and changes in key managers.
		Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process.
		Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	The registered nurses and the clinical manager held current annual practising certificates along with other health practitioner's involved with the service. Staff files included appointment documentation (e.g. signed contracts, job descriptions, reference checks and interviews). There is an appraisal process in place. All staff completed an orientation programme and health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Staff interviewed confirmed the review of the orientation programme with a new staff member stating that there is a robust process. Annual competencies are completed by care staff (e.g. hoist, oxygen use, hand washing, wound management, medication management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower). The organisation has a mandatory education and training programme. Staff attendances are documented. Education and training hours is at least eight hours a year for each staff member. Staff have completed training around management of behaviours that challenge.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy. There are 34 staff including clinical staff, an activities coordinator and household staff. There is always a registered nurse on each shift. The business and care manager and clinical manager are on call. Residents and families interviewed confirmed staffing is adequate to meet the residents' needs.

| Standard 1.2.9: Consumer Information Management Systems

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family.

There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information could be accessed in a timely manner.

Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member including designation.

Resident files are protected from unauthorised access by being locked away in an office.

Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual resident files demonstrated service integration. This included medical care interventions. Medication charts are in a separate folder with medication. Short term care plans and documentation around wounds are also kept in a separate folder to enable to staff to refer easily to this information. Staff interviewed state that they read the long term plans at the beginning of each shift. |
| Standard 1.3.1: Entry To Services

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry and assessment processes are recorded. The service's philosophy is displayed at the facility and communicated to residents, family, relevant agencies and staff. This facility operates 24 hours a day, seven days a week. The facility information pack is available for residents and their family and contains all relevant information.

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. The needs assessments are completed for rest home, hospital and young people with disabilities levels 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 conducted. |

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The clinical staff reported that: copies of the resident's records; recorded GP visits; medication charts; current care plans; upcoming hospital appointments and other medical alerts when a resident is transferred to another health provider.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medicine management system meets guidelines and current legislative requirements. In interviews, the RNs reported that prescribed medications are delivered to the facility and checked on entry. The medication area, including controlled drug storage evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidences weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded. 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. Medicine charts evidence: residents' photo identification; medicine charts are legible; as required (PRN) medication is identified for individual residents and correctly prescribed; 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). There was one resident self-administering medicines at the facility and did so according to policy.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service policies and procedures are appropriate to the service setting with seasonal menu reviewed by a dietitian. In interview, the head 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, confirmed at interview with the head cook. The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences are met and adequate food and fluids are provided. Residents are provided with choices of food daily. The residents under 65 years of age with disabilities are provided with buffet meals and are able to serve themselves and choose their own meals. The food temperatures were recorded as were the fridge, chiller and freezer temperatures. All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The scope of the service provided is identified and communicated to all concerned. The business and care manager stated that a process to inform residents and family, in an appropriate manner, of the reasons why the service is declined is implemented, when required. The residents are declined entry if not within the scope of the service or if a bed was not available. The resident would be referred back to the referring service.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate	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 DHB (where required) were available. The facility has appropriate resources and equipment, confirmed at staff interviews. 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.	PA Moderate	The residents' care plans are individualised, integrated and up to date. Short term care plans are developed, when required and signed off by the RN when problems are resolved. The residents have input into their care planning and review, confirmed at resident and family interviews. Regular GP care is implemented, sighted 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 GP documentation and records are current. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs (refer to criteria 1.3.4.2 and 1.3.5.2). Family communications are recorded in the residents' files. Nursing progress notes and observations charts are maintained.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	In interview, the activities coordinator (AC) confirmed the activities programme meets the needs of the service group and the service has appropriate equipment. The AC is employed Monday to Friday. They plan, implement and evaluate the activities programme. Regular exercises and outings are provided for those residents able to partake. Interviews with residents, family and staff confirm 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 activities coordinator conducts residents' activities and cultural assessments and these are communicated to the RNs. Activities care

		planning is part of the whole long term care plan and conducted by the RNs. The residents' activities attendance records are maintained. Physiotherapist is contracted for six hours a week and physiotherapy assistant works 4 hours a week.
		Younger residents with disabilities are provided with appropriate separate lounge and dining areas and are able to participate in aged appropriate activities.
		The residents' meetings are held monthly and alternate between young people with disabilities one month and rest home and hospital residents the next month. The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate	Time frames in relation to care planning evaluations are documented. The residents' files evidenced the residents' care plans are up-to-date and reviewed six monthly. There is evidence of resident, family, HCA, activities coordinator and GP input in care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews. 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 some of the residents' files, used when required. The family are notified of any changes in resident's condition, confirmed at family interviews. There is recorded evidence of additional input from professionals, specialists or multi-disciplinary sources, if this is required.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services. Completed referral forms / letters were sighted. This included referrals to DHB specialists. Family communication sheets confirm family involvement. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented.

Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff received training and education to ensure safe and appropriate handling of waste and hazardous substances. There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example: goggles/visors; gloves; aprons; footwear; and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed – expiry date 11 April 2015. There have been no building modifications since the last audit. There is a planned maintenance schedule implemented. The following equipment is available: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There is an annual test and tag programme and this is up to date with checking and calibrating of clinical equipment annually. Interviews with staff and observation of the facility confirms there is adequate equipment. There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provided privacy when required. During the audit, the deck and grass areas are well used with shade, seating and outdoor tables. There is a courtyard used predominantly by young people with disabilities and other courtyards for any resident to access.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Residents and family members report that there are sufficient toilets and showers. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Equipment is sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff and the resident. Rooms could be personalized with furnishings, photos and other personal adornments and the service encouraged residents to make the suite their own. There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required. Some residents have a larger room to accommodate specific aids.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The service has lounge/dining areas including areas that can be used for activities. One lounge can be used by any resident but is designated as a 'common room' predominantly for residents identified as under the age of 65 years. There is another large lounge identified as predominantly used by older residents. The common room has its own television and computer suite for use by residents. All areas are easily accessed by residents and staff. Residents are able

| | | to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.

Dining areas are located in the common room with this set up as a self-service option predominantly for younger residents and two other dining areas adjacent to each other for residents who are more able or less able to feed themselves. Residents can choose to have their meals in their room. |
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| Standard 1.4.6: Cleaning And Laundry Services

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is completed off site with covered laundry trolleys and bags in use for transport. There is a dirty area in the laundry to place the laundry bags ready for collection and a separate clean area for clothes and linen to be returned. Staff are required to return linen to the rooms. Residents and family members state that the laundry is well managed and they get back their clothes most of the time with staff following up on any lost items.

There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits. |
| Standard 1.4.7: Essential, Emergency, And Security Systems

Consumers receive an appropriate and timely response during emergency and security situations. | FA | An evacuation plan is approved by the New Zealand Fire Service in 1994. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff six-monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures.

There is always at least one staff member with a first aid certificate on duty.

All required fire equipment is sighted on the day of audit and all |

		equipment had been checked within required timeframes.
		A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, emergency lighting and a gas BBQ.
		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, dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells
		The doors are locked in the evenings. Staff complete a check in the evening that confirmed that security measures had been put in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There are two designated external smoking areas. Staff hold lighters and light each resident's cigarette as requested to ensure safety for all residents. Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control (IC) policies and procedures provide information and resources to inform staff on infection prevention and control. The delegation of infection control matters is documented in policies, along with an infection control nurse's (ICN) job description. The infection control nurse is the clinical leader/ registered nurse. There is evidence of regular reports on infection related issues and these are communicated to staff and management. The IC programme is reviewed annually.

Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IC nurse 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. The IC is an agenda item at the facility's meetings, evidenced during review of meeting minutes and interviews with staff.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The IC policies and procedures 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. The IC policies and procedures are developed and reviewed regularly in consultation and input from relevant staff. IC policies and procedures identify links to other documentation in the facility.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The service provider's documentation evidences that infection control 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. There is recorded evidence of written advice/ information for staff, visitors and residents relating to outbreak management. All 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. The ICN has attended an external education in IC.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed	FA	The clinical manager (CM) is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff.

objectives, priorities, and methods that have been specified in the infection control programme.		Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.
		Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.
		The infection control surveillance register included monthly infection logs and antibiotics use. The organisation had an internal benchmarking system. Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the staff meeting.
		The clinical manager (CM) is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.
		Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.
		The infection control surveillance register included monthly infection logs and antibiotics use. The organisation had an internal benchmarking system. Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the staff meeting.
		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.
		The infection control surveillance data was sampled through resident

		records, staff interviews and collated infection reports. This information confirmed the surveillance programme is appropriate and fully implemented. The infection control data is communicated to staff at facility's meetings. Infection logs are maintained for infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short term care plans.
		In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RN's, verbal handovers, handover sheets, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.
		In interview, the ICN confirmed there were no outbreak at the facility since last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The definition of restraint and enabler is congruent with the definition in the standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews. There were two residents who requested the use of enablers at the facility on audit days. The process of assessment, consent, care planning, monitoring and evaluation of enabler use is recorded, sighted in two of two residents' files. There were no residents using restraint at the facility on audit day.
		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.

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.

Citerion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes.	Some incidents are not documented and near misses are rarely documented. This was discussed with the business and care manager and clinical leader who started corrective actions once the issues had been identified during the audit.	Provide further training around documentation of incidents and near misses and ensure that these are documented as these occur. 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	Eight residents' files were reviewed. Residents' files and clinical staff interviews confirmed that the six of the eight residents' files were of residents that present with behaviours that challenge. In interviews the health care assistants (HCA) described the residents' behaviours, their triggers and how they de -escalate and manage the challenging behaviours. Not all HCAs	Residents' needs, outcomes and goals are not consistently identified via the assessment process and not always recorded.	Provide evidence of completion of required assessments 60 days

| | | interviewed were aware of the individual resident's triggers or the management of the individual challenging behaviours of residents. All of the six files reviewed of the residents' with challenging behaviour did not evidence challenging behaviour assessments.

In the resident's file of a resident who was assessed by the GP as requiring PRN pain relief did not evidence the effectiveness of the treatment (the PRN pain medication) on the pain monitoring tool or in the progress notes or reassessment of pain assessment completed medication chart evidenced the PRN pain relief was changed to regular pain relief to manage the pain. | | |
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| Criterion 1.3.5.2

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | All six files reviewed of the residents' with challenging behaviour did not evidence challenging behaviour assessments (criterion 1.3.4.2). The care plan interventions do not consistently reflect individualised care requirements relating to behaviours that challenge (six of six files). | The long term care plans do not consistently describes the required interventions around behaviours that challenge. | Provide evidence the long term care plans describe the required support and interventions relating to behaviours that challenge.

60 days |
| Criterion 1.3.8.2

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | I) Two of eight care plan evaluations did not evaluate all identified patients' needs; such as challenging behaviour and medical condition. Two of eight care plan evaluations (different files) did not record evidence of the degree of achievement towards meeting the residents' needs. Additional six hospital files were reviewed in relation to care plan evaluation. Two of the six additional hospital files did not record | i) Care plan evaluations are not consistently recorded for all identified needs and do not always indicate the degree of achievement towards meeting residents' goals. ii) Evaluations of wounds are not always completed according to the wound care plan evaluation timeframes. | Provide evidence that evaluations are documented for all resident's care needs and record the degree of achievement towards meeting these needs. |

		the evidence of the degree of achievement towards meeting the resident's needs. ii) Wound care folder was reviewed. Wound care plans evidence the reviews are not conducted according to the wound care plan evaluation timeframes.		60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.