

Oceania Care Company Limited - Elmwood Village

Introduction

This report records the results of a Surveillance 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: Elmwood Village

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

Dates of audit: Start date: 2 September 2015 End date: 3 September 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: 139

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
Yellow	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
Red	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

Elmwood Village (Oceania) can provide care for up to 139 residents requiring care at either rest home or hospital level with full occupancy on the day of audit. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the district health board contract.

The audit process included the review of policies and procedures, the review of 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 manager, clinical leaders and regional and executive management team. Service delivery is monitored.

All improvements required at the last certification audit to complaints management, care planning, administration of medication, documentation of maintenance checks and to the call bell system have been addressed.

This surveillance audit identified improvements required to review of care plans, advance directives and documentation of risks associated with restraint.

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.

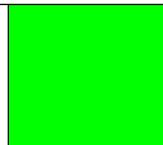


Standards applicable to this service fully attained.

Staff interviewed are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and care for the residents. Information regarding the complaints process is available to residents and their family and complaints reviewed are investigated with documentation completed and stored in the complaints folder. Staff communicate with residents and family members following any incident.

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.

Elmwood Village has implemented the Oceania quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and business status reports allow for the monitoring of service delivery. Benchmarking reports include clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented. Corrective action plans are documented with evidence of resolution of issues when these are identified.

Staffing levels are adequate across the service with human resource policies implemented. This includes evidence of robust recruitment and staffing.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Service delivery provides care to residents assessed as requiring rest home and hospital level care. The registered nurses develop, review, update and evaluate residents' care plans, however this was not consistently implemented at six monthly intervals. Residents have the opportunity to complete advanced directives, however resuscitation instructions were not consistently signed by the residents. Residents or their family have input into the development and review of care plans. Documentation provides evidence that families are kept informed. Residents interviewed are satisfied with the standard of care provided by staff.

The activity programmes support the interests, needs and strengths of residents. Residents and family interviewed confirm they participate in the activities, and that the programmes have a wide variety of activities to choose from.

An appropriate medicine management system is implemented, with policies and procedures recording service providers' responsibilities. Staff responsible for medicine management have current medication competencies. Medication files reviewed evidence documentation of residents' allergies/sensitivities and three monthly medication reviews completed by general practitioners. The medicine fridge temperatures are recorded and within the recommended range.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Residents' dietary needs are identified on admission, documented in nutritional profiles, and reviewed on a regular basis. Residents confirmed that adequate fluids are provided and snacks are available between meals.

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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There is a current building warrant of fitness. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family interviewed describe the environment as appropriate with indoor and outdoor areas that meet their needs. Areas are being refurbished throughout the site.

Restraint minimisation and safe practice

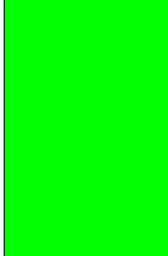
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Documentation of restraint minimisation and safe practice policies and procedures and implementation, demonstrate residents were experiencing services that are least restrictive.

Systems are in place to ensure assessment of residents is undertaken prior to restraint being implemented. Enabler use is voluntary and residents have the opportunity to make informed decisions about the use of enablers. The resident's files reviewed demonstrated restraint assessments were completed however it did not include the identification of restraint risks. The resident's files reviewed provided evidence of resident and family input into the restraint approval processes. Restraint evaluation processes were documented and implemented. Resident's files evidenced each episode of restraint being evaluated. Approved restraint for

residents was reviewed bi-monthly as part of the restraint approval and care plan review. Restraint usage across the facility is monitored and discussed at quality meetings.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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Staff education in infection prevention and control was conducted according to their education and training programme and recorded in staff files.

Infections are investigated and managed through the use of short term care plans. Appropriate antibiotics are prescribed according to sensitivity testing. Surveillance data is collected monthly for benchmarking. Appropriate interventions are in place to address the infections. There are adequate sanitary gels and hand washing facilities for staff, visitors and residents. Staff members were able to explain how to break the chain of infection.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	2	0	0	0
Criteria	0	46	0	2	0	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures are in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include timeframes for responding to a complaint. Complaint forms are available in the facility and family and residents interviewed know where they can get a form. One family member described a complaint which was documented on the complaints register with evidence that appropriate authorities were involved. The family member was satisfied with the outcome of the complaint and praised the service for the actions taken.</p> <p>The complaints register in place includes: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaints folder.</p> <p>Five complaints lodged in 2015 were selected for review. There is documented evidence of periods being met for responding to these complaints with complainants happy with the outcome in each case. Documentation for each complaint on file indicates that each complaint is thoroughly investigated with letters on file to confirm that complainants have been informed of receipt of the complaint and the outcome with any staff involved documenting actions taken. Documentation includes staff</p>

		<p>signatures, name and designation. The improvements required at the previous audit are met.</p> <p>There have not been any complaints with the Health and Disability Commission (HDC) or other authorities since the last audit. Responses to two outstanding complaints lodged with the Health and Disability Commissioner prior to the certification audit acknowledge that both are closed with no further actions required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accidents/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is available.</p> <p>Family are informed if the resident has an incident, accident, a change in health or a change in needs as confirmed in a review of 10 accident/incident forms and in the resident files.</p> <p>Files reviewed include documentation around family contact. Interviews with family members confirm they are kept informed. Family confirm that they are invited at least six monthly to the care planning meetings for their family member.</p> <p>Interpreting services are available when required from the district health board. The business and care manager stated that families are involved in resident care and can interpret when required. The health and disability advocate attends the monthly resident meeting and completes training for staff. The advocate also visits the business and care manager at least monthly to offer any support to residents required. The advocate can also organise interpreting services if required. At the time of the audit, there were two residents requiring interpreting services for specific tasks and family and staff interpret on a day-to-day basis for them. A family member interviewed stated that the resident who did not speak English was well supported by staff on each shift who spoke the family member's language.</p> <p>All residents interviewed confirm that staff are approachable and communicate well.</p> <p>An information pack is available in large print and staff interviewed advised that this could be read to residents.</p> <p>Staff training records include annual training around connecting with people and communication.</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>Elmwood Village is part of the Oceania Care Company Limited with the executive management team including the chief executive officer, general manager, operations manager, regional operational manager and clinical and quality manager providing support to the service.</p> <p>Communication between the clinical and quality manager, the regional operations manager and the business and care manager takes place on a regular basis (at least once a month) with more support provided as required.</p> <p>Oceania has a clear mission, values and goals and staff interviewed were able to describe these. These were observed to be displayed in the foyer of the service.</p> <p>The facility can provide care for up to 139 residents requiring rest home or hospital level of care (42 rest home beds, 67 hospital and 30 dual-purpose beds). During the audit there was full occupancy.</p> <p>The business and care manager is responsible for the overall management of the facility and has been in the role since 2008. The business and care manager is a registered nurse (with a current annual practicing certificate) and has a masters degrees in relevant areas including business, midwifery and education. The business and care manager is supported by a clinical manager and two clinical leaders (registered nurses). The clinical manager has been in the role for six months and has over 20 years' experience in acute nursing. The clinical leaders are newly appointed and both have a postgraduate certificate relevant to the service. Both have over three years' experience in aged care.</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>Elmwood Village uses the Oceania quality and risk management framework that is documented to guide practice. The business plan is documented and reporting occurs through the business status reports. This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required, with all policies current. 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 and new and revised policies are signed by staff to say that</p>

		<p>they have read and understand them.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. Quality improvement data is analysed and corrective action plans are documented with evidence of resolution of issues.</p> <p>There are monthly meetings with minutes documented that include the following: management, health and safety; restraint, weight, falls, infection control and quality/staff. Clinical meetings are held two weekly with resident and family meetings held monthly.</p> <p>All staff interviewed report that they are kept informed of quality improvements.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are also in place for the service, which includes a documented hazard management programme and a hazard register for each part of the service. Any hazards identified are signed off as addressed or risks are minimised or isolated.</p> <p>There is an annual satisfaction survey for residents and family. The survey completed in 2015 indicates that residents and family are satisfied or very satisfied with care and support provided. The business and care manager is currently documenting a corrective action plan. The recommendations identified as a result of the 2014 survey have been completed with improvements implemented.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The business and care manager and clinical manager are aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks. Times when authorities have had to be notified are documented and retained on the relevant file. This includes notification of the new clinical manager to HealthCERT.</p> <p>The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff records reviewed demonstrate that staff receive education at orientation on the incident and accident reporting process. Staff interviewed understand the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Incident reports selected for review have a corresponding note in the progress notes</p>

		<p>to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities.</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>Human resource policy and processes are in place. All registered nurses hold current annual practising certificates. Current visiting practitioners' practising certificates reviewed are current and include the general practitioners, pharmacists, dietitian, podiatrist and physiotherapist. Staff files include employment documentation such as job descriptions, contracts and appointment documentation on file. Police and drug checks are completed and an annual appraisal process is in place with all applicable staff having a current performance appraisal.</p> <p>A comprehensive orientation programme is available for staff. The programme has been reviewed and staff state that there is an improved satisfaction with the orientation. Preceptors are appointed and there is a longer time given for new staff to complete orientation. Staff files show completion of orientation. Staff are able to articulate the buddy system in place and the competency sign off process completed.</p> <p>Mandatory training is identified on an Oceania wide training schedule. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training held. The service has a varied approach to ensuring that staff receive annual training that includes attendance at training sessions and annual individualised training around core topics such as medication, restraint, infection control, health and safety, manual handling and continence. Registered nurses have an hour of training at each meeting that includes relevant topics such as pain management, complaints management, nutrition, assessments, medication administration and falls. The training register and training attendance sheets show staff completion of annual medication and other competencies such as hoist; oxygen use; hand washing; wound management; moving and handling; restraint; nebuliser; blood sugar and insulin.</p> <p>Education and training hours exceed eight hours a year for all staff reviewed. Sixty percent of health care assistants have completed level four training around aged care including training around dementia and a further eighteen percent of health care assistants have completed level three training. Others are either newly appointed or completing orientation or have been with the service for over 25 years.</p>

		The health care assistants state that they value the training.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>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 meet resident acuity and bed occupancy. Rosters particularly for one area with dual-purpose beds were checked to ensure that residents requiring either hospital or rest home level of care were well supported according to individual need. Evidence reviewed and observations confirmed that residents requiring hospital level of care were well supported with a registered nurse on duty at all times. Residents requiring rest home level of care were encouraged to be as independent as possible.</p> <p>There are 21 serviced apartments in the same building as the rest home and hospital. There is a process followed by staff should a resident ring the call bell from a serviced apartment. A book records any calls and the registered nurse or health care assistant attend as required and as per policy. Staff from an adjoining wing can provide support if required noting that there are always staff left in the hospital and rest home areas relevant to the needs and acuity of residents. Currently there are three residents who receive medication and this is documented. Staffing is adequate in the adjoining rest home wing and can accommodate the administration of medication to these residents.</p> <p>Staff can attend a call out from a village resident (independent units), however the documentation indicates that a call out is rare and an ambulance is called as and when required. Documentation indicates that any staff attending a call does so to check on the resident and to escalate the issue if required. Home support is not provided to residents occupying independent units.</p> <p>Residents and families interviewed confirm that staffing is adequate to meet the residents' needs.</p> <p>There were 139 staff at the time of the audit including the business and care manager, the clinical manager and two clinical leaders, registered nurses and health care assistants. Household staff are appointed.</p>
Standard 1.3.12: Medicine Management	FA	Medicine management policies and procedures are in place and implemented and

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>include: processes for safe and appropriate prescribing; dispensing; and administration of medicines. Medicine charts list all medications the resident is taking. Medication charts are signed by the GPs. All entries are dated and allergies recorded. All charts have photo identification. Discontinued medicines are signed and three monthly GP medication reviews are consistently completed at three monthly intervals.</p> <p>All medicines are prescribed by the GPs. Medication reconciliation policies and procedures are implemented.</p> <p>During the lunch time medication administration round the staff member completed the round according to the requirements for safe and appropriate medicines administration. Education in medicine management is conducted. Staff who are authorised to administer medications are required to complete medication competency testing, in theory and practice. All staff members responsible for medicines management complete annual competencies.</p> <p>Self-administration of medicine policies and procedures are in place and sighted. There were three residents who self-administered their own medications. All residents who self-administer medicines have competencies signed off, have secure storage for their medicines and checks by the registered nurses to ensure the medicines are taken.</p> <p>The previous requirement for improvement relating to transcribing of medicines is fully implemented.</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>	<p>FA</p>	<p>Individual food, fluids and nutritional needs of residents are met. The meals are prepared and cooked on-site. The menus are reviewed by the dietitian for summer and winter use. The menu review was based on nutritional guidelines for the older people in long-term residential care and rolls over every four weeks.</p> <p>Dietary assessments are completed on admission by the registered nurses or the clinical manager. This information is shared with kitchen staff to ensure all needs, food allergies, likes, dislikes and special diets are catered for. The facility provides modified diets for example; puree diets to meet the dietary needs of the residents.</p> <p>The chef interview confirmed documented kitchen routines for cleaning and routine checks; for example temperature checks of the fridges, freezers and food. Nutrition and safe food management policies define the requirements for all aspects of food safety. Labels and dates on all food containers are maintained. The chef and the</p>

		cook have current food handling certificates. All aspects of the food service; procurement, production, preparation, storage, delivery and disposal, comply with current legislation and guidelines.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The PCCPs of all the reviewed residents' files cover additional issues as identified during the assessment process, for example pain management where residents receive controlled drugs. Short term care plans are developed where residents are identified with infections and / or wounds.</p> <p>The previous requirement for improvement relating to PCCP's and short term care plans to describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process is fully implemented.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Interventions are documented for each goal in the PCCPs, evidenced during the review of the PCCP's. Assessments reflect additional considerations for example: pain management; dietary likes and dislikes; gait and balance. Interview with the GP confirmed clinical interventions are effective and appropriate.</p> <p>Residents and family involvement in the development of goals and review of the PCCP's is encouraged, confirmed during resident interviews. Multidisciplinary meetings are conducted. All resident files reviewed during the on-site audit were signed by either the resident or by their family member. Interventions from allied health providers are recorded for example: notes from the dietitian; the speech language therapist; the physiotherapist and the needs assessment service coordinators (NASC).</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Residents confirmed they have choices regarding what activities they participate in and contribute to planning their own activities. The diversional therapist (DT) coordinates the activity programmes. The DT provides different activities addressing the abilities and needs of residents in the hospital and rest home, including four residents that were under 65.</p> <p>During the onsite visit, activities included residents going for an outing, having choir practice and entertainment. Residents and family confirmed they were satisfied with the activities programme. Each resident has access to an activities programme and</p>

		<p>those that wanted their own copy had it displayed in their bedroom.</p> <p>On admission the DT completes a recreation assessment for each resident. The recreation assessments include: personal interests; family history; work history and hobbies to ensure resident's participation in the activities. The DT provides the RNs with the recorded assessments to ensure it is included in the PCCPs. Review of activity plans showed six-monthly reviews.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' files reviewed showed PCCP's were not consistently reviewed at six monthly intervals (refer to criterion 1.3.3.3). Clinical reviews are documented in the multi-disciplinary review (MDR) records, which include review of the care plans by registered nurses, input from the GP, HCAs, DT and other members of the allied health team. Progress notes reflect daily response to interventions and treatments and are completed by the HCAs and RNs. Continuity of care is reflected in the handover booklets.</p> <p>Changes to care are documented in the care plans. Residents are assisted in working towards their goals. Short term care plans are developed for acute problems for example: infections; wounds; falls and other short term conditions.</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 posted in a visible location at the entrance to the facility (expiry date March 2016). There have been no building modifications since the last audit however there is refurbishment of the interior being completed.</p> <p>A planned maintenance schedule is implemented and the maintenance staff and documentation confirmed implementation of this. The improvement required at the previous audit is met.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids.</p> <p>Equipment relevant to care needs is available and staff confirm that there is always sufficient. A test and tag programme is in place. Equipment is calibrated.</p> <p>There are safe external areas for residents and family to meet/use and these include paths, seating and shade.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>An evacuation plan was approved by the New Zealand Fire Service in January 2008. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place at least six monthly with individual training for staff annually. The orientation programme includes emergency and security training. Staff confirm their awareness of emergency procedures.</p> <p>There is always one staff member at least with a first aid certificate on duty with all registered nurses having a current first aid certificate.</p> <p>All required fire equipment is checked within required timeframes by the external contractor. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. Back up emergency lighting is in place and this is fully checked and run for two hours annually.</p> <p>The doors are locked in the evenings and can only be opened from the inside. Systems are in place to ensure the facility is secure and safe for the residents and staff. External lighting is adequate for safety and security with sensor lights on the outside of the building.</p> <p>The call bell system has been replaced with an external company on call should any maintenance be required. The call bell system works wirelessly but can operate on battery or on mains. Calls are displayed on a monitor and calls from shared areas, apartments or the village are sent directly to pagers. The system escalates calls if they are not answered within a defined time. The improvement required at the previous audit has been addressed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organization. Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators on the intranet.</p> <p>Residents with infections have short-term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported monthly at staff, quality, and infection control and health and safety meetings. Interviews confirmed information relating to infections is made available for clinical staff during</p>

		hand over and at staff meetings.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	PA Low	<p>Restraints used in the facility include lap belts and bedrails. There were three residents using restraints and no residents using enablers. The files reviewed for restraint and enabler use showed enabler use has to be voluntary and the service uses the least restrictive option of restraint for the residents.</p> <p>The restraints are documented in their PCCP's; however the restraint risks were not identified during the assessment process. The service recorded potential risks for residents during the time of the on-site audit. There were no restraint related injuries reported. Bedrails had specialised bedrail covers when in use.</p> <p>The service has a documented system in place for restraint use, including a current restraint register. Reasons for restraint use are considered. The service appointed a registered nurse in the role of the restraint coordinator.</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>	PA Low	<p>Both the residents' files reviewed during tracer methodology showed NFRs signed by enduring power of attorneys (EPOA's). The auditors extended the NFR checks to all resident files reviewed on the day of the on-site audit and found that five of the nine files reviewed had EPOA's sign the NFR consent.</p> <p>Of the nine resident files reviewed, two PCCP's were not reviewed within the required timeframe of six months.</p>	<p>i) The PCCPs assessed during the on-site audit were reviewed; however the reviews did not consistently occur within the required six month timeframe.</p> <p>ii) NFR (not for resuscitation) consents were signed by enduring power of attorneys (EPOA's).</p>	<p>i) All PCCP's to be reviewed at least six-monthly or when the resident's condition changes.</p> <p>ii) The NFR instruction can only be signed by the resident.</p> <p>90 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of</p>	PA Low	<p>Records include assessments, consents, monitoring and evaluation forms, consent forms, authorisation and plans. Reasons for restraint use are considered.</p>	<p>The restraint assessment process included opportunity to document potential risks related to restraint use; this was completed during the on-</p>	<p>Risks relating to restraint to be recorded for all residents who use restraint.</p>

promoting or maintaining consumer independence and safety.			site audit.	30 days
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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.