

Oceania Care Company Limited - Elmswood Rest Home

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: Elmswood Rest Home

Services audited: Dementia care

Dates of audit: Start date: 8 March 2016 End date: 9 March 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 34

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

This certification audit was undertaken to monitor compliance with the Health and Disability Service Standards and the district health board contract. Elmswood Home is operated by the Oceania Care Company limited Elmswood Home and is a dementia unit. Elmswood Home can provide care for up to 38 residents. On the days of this audit there were 34 residents. The audit process included review of policies and procedures, sampling of resident and staff files, observations, interviews with residents and their families, management, staff and a general practitioner.

This certification audit identified improvements required to aspects of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the quality and risk management programme, documentation and infection control.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights information (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, was accessible. This information is given to residents' and their families on admission to the dementia unit. There are requirements for improvement relating to dignity, respect and open disclosure. Residents and family interviewed confirmed consent forms are provided. There is a requirement for improvement relating to maintaining the complaints register.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Oceania Care Company Limited is the governing body and is responsible for the services for dementia care, provided at the Elmswood Home. The business and care manager is appropriately qualified and experienced. The clinical manager is new to the role and responsible for oversight of clinical care. HealthCERT received notification of this appointment.

Risks are identified and the hazard register is up to date. Adverse events are documented on incident and accident forms. Quality improvement data is collected, collated, analysed and reported through the use of their national quality system; however there are requirements for improvement relating to recording of meeting minutes, corrective action plans and recording of names and designations.

Policies and procedures relating to human resources management processes govern their practices. Staff education records confirmed in-service education is provided. The business and care manager validates annual practising certificates for health professionals who require registration with their professional bodies. A documented rationale for determining staffing levels and skill mix was reviewed. The clinical manager is available after hours if required for clinical support. Care staff, residents and family report that there is adequate staff available.

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.		Standards applicable to this service fully attained.
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Residents receive services from suitably experienced staff. Residents' files demonstrate initial assessments, initial care plans, and long term care plans are conducted within the required timeframes. Care plan evaluations are documented, resident focused and indicate progress towards meeting residents' desired outcomes. Where progress of a resident is different from expected, the service responds by initiating changes to the long term care plan. Short term problems are recorded on short term care plans. Family have the opportunity to contribute to care planning and care plan reviews.

Recreational assessment and 24 hour recreational plans are completed for all residents. Activities are planned by the diversional therapist and the programme is available to residents.

The medication management system evidences compliant processes for reconciliation, prescribing, administration, dispensing, storage and disposal of medicines. Medicine management training is conducted annually. Self-administration of medicines is not practiced at this dementia unit. All staff responsible for medicines management have current medication competencies.

The food service at the facility is provided from another Oceania facility. Food and nutritional needs of residents are provided in line with recognised nutritional guidelines and menus are reviewed by a dietitian. Food service complies with current legislation and guidelines.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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All resident bedrooms provide single accommodation and the majority of residents are sharing communal bathroom facilities. Residents' rooms have adequate personal space. Lounges and dining areas are available for residents and external areas are available for sitting. Shade is provided.

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

Chemicals, linen and equipment are safely stored. Laundry services are provided by another service and delivered to the service. The service has a current building warrant of fitness which expires in May 2016. The preventative and reactive maintenance programme includes equipment and electrical checks

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. There were no residents using restraint or requiring enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour has been provided.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.
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The service provides an environment which minimises the risk of infection to residents, staff and visitors. There is an infection prevention and control programme which is reviewed annually. An infection control nurse is responsible for this programme.

Infection prevention and control education is included in the staff orientation programme, and in the in-service education programme. There is a requirement relating to the infection control nurse's additional education in infection control.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance and benchmarked against other Oceania facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	39	0	3	3	0	0
Criteria	0	86	0	4	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff received education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service. This also forms part of their annual mandatory education programme. Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, especially regarding maintaining of residents' privacy, providing residents with choices and encouraging independence.</p> <p>The information pack provided to residents on entry includes information on how to make a complaint and brochures on the Code. Care staff were respectful towards residents and family members.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has systems in place to ensure residents, and where appropriate, their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The clinical manager and business and care manager report informed consent is discussed and recorded at the time the resident is admitted to the facility. Family interviews confirmed they have been made aware of and understand the principles of informed consent. Copies of legal documents such as Enduring Power of Attorney (EPOA)</p>

		for residents are retained at the facility where residents have named EPOAs.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>The service has appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. The facility manager advised that the independent advocate visits the service regularly. Care staff interviewed demonstrated an understanding of how residents can access advocacy and support persons.</p> <p>Family interviewed confirmed that advocacy support is available to them, if required. They also confirmed this information was included in the information package they received on admission. The nationwide advocate details are displayed along with advocacy information brochures. Admission information was reviewed and provided evidence advocacy, complaints and the Code information is included.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Family interviews confirmed residents have access to visitors of their choice. The service has a van available to take residents on community visits and outings. Residents go out with family. Visitors' policy and guidelines are available to ensure resident safety and well-being is not compromised by visitors to the service. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Moderate	<p>The service records complaints, the investigation of complaints. There is an improvement required to management of complaints. The business and care manager disclosed there had been one Health and Disability Commissioner enquiry, which had been closed and another enquiry is still outstanding since the previous audit, at this facility. Te documentation was reviewed by the auditor during the onsite audit.</p> <p>Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. The complaint process was readily accessible and complaints forms are displayed for easy access; however the complaints register was not up-to-date. Residents and family interviewed confirmed having an understanding and awareness of how to make a complaint; however some of the complaints referred to during family interviews were not reflected in the complaints register. Resident meetings are held monthly and residents and their families are able to raise any issues they have during these meetings, confirmed during interviews.</p>

		Complaints policies and procedures are compliant with Right 10 of the Code.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code and information on the advocacy service are available and displayed in English and Te Reo. The admission information packs reviewed included information on the Code, advocacy and complaints processes. Family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to admission.</p> <p>Residents and family interviewed received copies of the Oceania Handbook. Interviews confirmed explanations regarding their rights occurred on admission. Families and residents are informed of the scope of services. This is included in the service/admission agreements.</p> <p>Family interviewed confirmed they had access to an advocate, if needed. The business and care manager advised that an advocate visits the facility on a regular basis and is also responsible for taking resident meetings. The completed resident and family survey questionnaires indicated residents/family are aware of their rights and are satisfied with this aspect of service delivery.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	PA Low	<p>Staff receive training on abuse/neglect as part of the in service education programme. Staff were observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Care staff interviewed demonstrated an awareness of residents' rights and the maintenance of professional boundaries. Residents were observed being treated with respect by care staff during this audit. However, family interviews and incident reports showed consistent loss of resident's personal clothing over the previous three months.</p> <p>Activities and outings in the community are encouraged, and are part of the resident's activities plan. Values, beliefs and cultural aspects of care were recorded in residents' clinical files reviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner</p>	FA	<p>The Māori health plan describes that the holistic view of Māori health is to be incorporated into the delivery of services. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. Access to Māori support and advocacy services is available, if required from a local provider of health and social services.</p>

<p>that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>Staff members also provide cultural advice and support for staff if required. A cultural assessment is completed as part of the care plan for all residents. Specific cultural needs are identified in the residents' care plans and this was sighted in files reviewed. Staff were aware of the importance of whānau in the delivery of care for the Māori residents. Family/whānau are able to be involved in the care of their family members.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Documentation provided evidence that appropriate culturally safe practices are implemented and maintained, including respect for residents' cultural and spiritual values and beliefs. The organisations documentation lists the details on how to access appropriate expertise including cultural specialists and interpreters. Residents' files demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whānau contact details. The service has one residents identifying as Māori.</p> <p>Residents interviewed confirmed their culture, values and beliefs are being respected, and their spiritual needs are met. During interview, care staff demonstrated an understanding of cultural safety in relation to care and confirmed that processes are in place for residents to have access to appropriate services, ensuring their cultural and spiritual values and beliefs are respected.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Oceania's policies and procedures outline processes to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct.</p> <p>Staff files reviewed included copies of the code of conduct that all staff are required to adhere to. Conflict of interest issues, including the accepting of gifts and personal transactions with residents are included in the staff training, policies and procedures. Expected staff practice is outlined in job descriptions and employment contracts, which were reviewed on staff files.</p> <p>Review of the adverse events reporting system, complaints register and interview of the business and care manager indicates there have been no allegations made by residents of unacceptable behaviour by staff members. Residents and family interviewed reported that staff maintain appropriate professional boundaries.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Education is provided by specialist educators as part of the in-service education programme which is overseen by the clinical manager with input from the business and care manager and the regional clinical quality manager. The district health board (DHB) also provides education as part of the in service education programme.</p> <p>The clinical quality manager, the business and care manager and the clinical manager/registered nurse described the process for ensuring service provision is based on best practice, including access to education by specialist educators. Staff interviewed confirmed an understanding of professional boundaries and practice.</p> <p>Documentation reviewed provided evidence that policies and procedures are based on evidence based rationales.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>PA Moderate</p>	<p>Open disclosure policy and procedures were in place to ensure staff maintain open, transparent communication with residents and families. However interviews with families confirm a lack of communication with service providers and incident and accident records do not consistently confirm communication with family through the notification process. The residents' files reviewed provided evidence that communication with family members was being documented in residents' records. There was evidence of communication with the general practitioner (GP) and family following adverse events.</p> <p>The business and care manager advised access to interpreter services is available if required via the district health board if required. They also advised there were no residents who required interpreter services. Residents interviewed confirmed that they are aware of the staff that are responsible for their care. Admission agreements reviewed were signed and dated on admission.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Oceania Care Company Limited's vision, values, mission statement and philosophy are displayed at the entrance to the facility. The organisation has systems in place recording the scope, direction and goals of the organisation. The business and care manager and the clinical manager provide monthly reports to the support office. Business status reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audits and clinical indicators (refer to 1.2.3.6 and 1.2.3.8). The business and care manager had been in this position for more that ten years and completed various management qualifications.</p> <p>The service has a business and care manager, supported by a newly appointed clinical</p>

		<p>manager and regional clinical quality manager (CQM). The clinical manager/RN is employed in a full time position to work with the business and care manager and has responsibility for all clinical matters. The CM from another facility stands in for the CM when on leave. The clinical manager's appointment was confirmed with HealthCERT, auditors sighted a copy of the notification during the onsite audit days.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the business and care manager (BCM) and / or the clinical manager (CM) be absent. The CM or the clinical quality manager stands in when the business and care manager is absent. Support is also provided by the regional operations manager and the senior clinical quality manager from the support office. The CM confirmed their responsibility and authority for this role.</p>
<p>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>	PA Moderate	<p>A quality improvement plan with quality objectives, including a quality and risk management plan and business plan was reviewed. These are used to guide the quality programme and include goals and objectives. Internal audits for 2015 /2016 were reviewed.. Family/resident and staff satisfaction surveys are completed as part of the audit programme and collated results for surveys were reviewed. Risks are identified and minimised. There is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures.</p> <p>Monthly quality and resident meetings are held. There is a requirement for improvement relating to meeting minutes not providing sufficient evidence to support the content of discussion and decision making as a result of the meeting. There was evidence this information is being reported to staff at staff meetings. There is a requirement for improvement relating to quality improvement data, including internal audits and incident/accident reports not addressing areas requiring improvement appropriately.</p> <p>There is a system in place for reviewing and updating policies and procedures regularly, including a policy for document update reviews and document control. Staff confirmed during interviews that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for service delivery.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse, unplanned or untoward events on an accident / incident form. This was confirmed in clinical records and during family/resident interviews. Incident and accident forms are reviewed and signed off by the business and care manager (refer to 1.2.3.8). There is an open disclosure policy.</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checking, criminal vetting, completed orientations and competency assessments.</p> <p>Copies of annual practising certificates were reviewed for all staff that require them to practice and are current. The clinical manager is responsible for the in-service education programme. Competency assessment questionnaires were available and completed competencies were reviewed. All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are supported to complete education via external education providers, including training on dementia care. Staff complete annual training on the management of challenging behaviour. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The business and care manager advised that staff are orientated at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed an orientation, including competency assessments.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	<p>FA</p>	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided 24 hours a day. On call after hours RN support and advice is provided by the clinical manager. The minimum amount of staff on duty is during the night and consists of one RN and three</p>

<p>and/or experienced service providers.</p>		<p>caregivers.</p> <p>Care staff interviewed reported there are adequate staff available and that they are able to get through their work. Residents are supervised in communal areas. There is at least one staff member with a current first aid certificate on each shift. Residents and family interviewed reported staff provide them with adequate care.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>PA Low</p>	<p>Resident information was entered in an accurate and timely manner into a register on the day of admission, using the 'Peoples Point' system. Resident files are integrated and recent resident information is located in residents' files. Resident files reviewed provided evidence that an entry into the residents' clinical record includes the time of entry, the date and entries are dated. Entries to the residents' daily record do not consistently show the name or designation of the service provider. Approved abbreviations are listed.</p> <p>Residents' information is stored securely in staff areas. Clinical notes are current and accessible to all clinical staff. Individual resident files demonstrated service integration. This included medical care interventions. Medication charts are in a separate folder with medication. The resident's national health index (NHI) number, name, date of birth and general practitioner (GP) are used as the unique identifier. Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Entry and assessment processes are recorded and implemented. The service's philosophy is displayed at the facility and communicated to residents, family, relevant agencies and staff. The facility information pack is available for residents and their family (refer to 1.1.9).</p> <p>The residents' admission agreements evidence family, EPOA 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 dementia level of care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition, appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in residents' files.</p>

transfer from services.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy and procedures are comprehensive and identify all aspects of medicine management.</p> <p>A safe system of medicine administration was observed on the days of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines have current medication competency assessments.</p> <p>Controlled drugs are stored in separate locked cupboard. The controlled drug register evidences weekly and six monthly stock checks and accurate records.</p> <p>The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date are recorded on the commencement and discontinuation of medicines, allergies are identified and three monthly medication reviews are conducted. There are no residents who self-administer medicines at the facility.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food service policies and procedures are appropriate to the service setting with a new seasonal menu being introduced six monthly. The menu is reviewed by a dietitian. Food is cooked at Melrose Park (Oceania facility located across the road from Elmswood Home and delivered in hot boxes to the Elmswood Home satellite kitchen. Lunch time food service was observed. Interviews with the kitchen manager at Melrose Park confirmed awareness of Elmswood Home residents' dietary requirements. Residents' dietary sheets are located at Melrose Rest Home and Village for kitchen staff's reference.</p> <p>Interview with a kitchen hand at Elmswood Home confirmed awareness of residents' dietary preferences and food allergies. Residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review, confirmed at clinical manager interview. There are current copies of residents' dietary profiles in the Elmswood Home satellite kitchen, sighted. In the Elmswood Home satellite kitchen food temperatures are recorded, kitchen fridge, and freezer temperatures are recorded and decanted food is dated.</p> <p>The food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines,</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>In interview, the clinical manager verified a process exists for informing residents, their family/whānau and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents have their needs identified through a variety of information sources that include: the needs assessment and service coordination (NASC) agency; other service providers involved with the resident; family/whānau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident's bedroom with the resident and/or family/whānau present, if requested.</p> <p>Over the three weeks post admission, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. A management plan for behaviours that challenge are completed recording specific interventions and activities to be used for behavioural management over 24 hours.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Residents' care plans are individualised, and current. The assessment findings are recorded in the care plans and describe the support the resident needs to meet their goals and desired outcomes. Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written.</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>Documentation, observations and interviews verified the provision of care provided to residents is consistent with residents' needs and desired outcomes. Care plan interventions are updated to reflect latest assessment findings.</p> <p>There are sufficient supplies of equipment seen to be available that comply with best practice guidelines and meet the residents' needs. Interview with the clinical manager confirmed equipment when required can be accessed from another Oceania facility located over the road (Melrose Rest Home and Village).</p> <p>Management plan for behaviours that challenge are completed with specific interventions</p>

		and activities to be used for behavioural management over 24 hours.
<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 are assessed on admission to determine their appropriate individual diversional and recreational requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents and provided five days a week. In interview, the diversional therapist (DT) confirmed the activities programme meets the needs of the service group and the service has appropriate equipment.</p> <p>The activities staff plan, implement and evaluate the activities programme. Along with the activities staff, the health care assistants (HCAs) implement individual resident's activities, as recorded on the residents' 24 hour activities care plans. Interviews with HCAs confirmed this.</p> <p>Regular exercises and outings are provided for those residents able and willing to partake. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. There are current, individualised activities care plans in residents' files. The residents' and family meeting minute's evidence residents' involvement and consultation of the planned activities programme (refer to 1.2.3).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN or the clinical manager.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service responds by initiating changes to the long term care plan.</p> <p>A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.</p> <p>Evaluations of the interventions on the behavioural management plans are conducted monthly or more frequently depending of the frequency of the behaviours that challenge.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or the RN sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and the hazard register is current. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There is provision and availability of personal protective clothing and equipment including; goggles/visors; gloves; aprons; footwear; and masks. During a tour of the facility, personal protective clothing and equipment was observed in areas where there were risks.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed; the date of expiry is 16 May 2016. There have been no building modifications since the last audit. The service has a planned maintenance schedule implemented with an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually.</p> <p>Interviews with staff and observation of the facility confirm there is adequate equipment including; pressure relieving mattresses; shower chairs; hoists and sensor alarm mats.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet providing privacy when required. There are internal courtyards and lawn areas with shade, seating and outdoor tables. The service is a secure unit for residents identified as requiring dementia care. Access into the service from the foyer is through touch pads and key pads are used to exit the unit.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing</p>	FA	<p>There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet</p>

<p>Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members report that there are sufficient toilets and showers with some rooms with their own en-suite. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to safely move around within the room. Equipment is sighted in rooms requiring this with sufficient space for both the equipment, for example; hoists, at least two staff and the resident. Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own.</p> <p>There is room to store mobility aids, such as walking frames, in the bedroom safely during the day and night, if required.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has lounge and dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, when required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.</p> <p>The dining areas have ample space for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry services are completed at another Oceania service provider and delivered to Elmswood Home in covered laundry trolleys and bags. There are designated clean and dirty areas in the laundry with separate doors to take clean and dirty laundry in and out. Laundry staff are required to return linen to the rooms. Residents and family members state they have concerns with regards to loss of personal laundry (refer to 1.1.3.1).The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be</p>

		with them at all times. Cleaners were observed on the days of the audit keeping the cleaning trolley in sight. All chemicals are in appropriately labelled containers. Laundry chemicals are administered through a closed system which is managed by a chemical contractor company. Products are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>An evacuation plan was approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. All required fire equipment is sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including: food; water; blankets; emergency lighting and gas BBQ's. An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways and dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells. There is always at least one staff member with a first aid certificate on duty with twenty care staff having completed first aid training.</p> <p>External doors leading to the gardens are locked after sun-set. Staff complete a check in the evening that confirms that security measures are in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever possible. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature. Family and residents confirm that rooms are maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be</p>	FA	<p>The infection control (IC) policy and procedures provide information and resources to inform staff on infection prevention and control. The delegation of infection control matters is documented in policy, along with an infection control nurse's (ICN) job description. The ICN is the clinical manager from another Oceania facility (Melrose Rest Home and Village)</p>

<p>appropriate to the size and scope of the service.</p>		<p>located across the road from Elmswood Home.</p> <p>There is a companywide Oceania IC committee, which is led by the Oceania general manager, aged care. The IC programme is reviewed annually by the Oceania infection control committee and communicated to individual Oceania facilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICN has access to relevant and current information, which is appropriate to the size and complexity of the two Oceania services (Elmswood Home and Melrose Rest Home and Village). Interview with the ICN confirm access to the district health board (DHB) infection prevention and control specialists, public health and clinical and quality manager at Oceania.</p> <p>The IC meetings have commenced in December 2015 and are conducted bi-monthly. The IC meetings are held at Melrose Rest Home and Village with the IC committee members selected from Melrose Rest Home and Village staff. The meeting minutes from the IC meetings evidence not all areas relating to IC are discussed and there is inconsistent evidence of regular reports on infection related issues to staff and management at Elmwood Home (refer to 1.2.3).</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The IC policies and procedures are reviewed by the company wide Oceania infection control committee and are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interviews. IC policies and procedures identify links to other documentation in the facility</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>PA Low</p>	<p>The IC education is provided to all staff, as part of their orientation and as part of the on-going in-service education programme.</p> <p>The IC staff education is provided by the ICN and by self-directed learning. Education sessions have evidence of staff attendance/ participation and content of the presentations. Staff are required to complete IC competencies, sighted in staff files and confirmed at staff interviews. ICN has not completed IC education relevant to their role.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The clinical manager at Elmswood Home is responsible for the surveillance programme. The business and care manager oversees both facilities (Elmswood Home and Melrose Rest Home and Village) coordinating services between the two facilities, including infection control (IC).</p> <p>The surveillance programme monitors the numbers and types of infections occurring at the facility. The IC meetings are conducted at Melrose Rest Home and Village and the content of the meeting requires include all relevant IC data (refer to 1.2.3). The surveillance data is used for benchmarking against other Oceania facilities. Monthly surveillance analysis is completed and reported on the Oceania intranet.</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files evidence the residents' who are diagnosed with an infection have short term care plans.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RN's, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interviews, the ICN and the clinical manager confirm no outbreak had occurred at the Elmswood since last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enabler is congruent with the definition in the standard. There were no residents at the facility using enablers or residents using restraint on audit days. The restraint coordinator is the clinical manager from another Oceania facility (Melrose Rest Home and Village) located over the road from Elmswood Home. Interview with the restraint coordinator confirmed there have been no restraints or enablers used at the facility in the past. The business and care manager oversees both facilities (Elmswood Home and Melrose Rest Home and Village) coordinating services between the two facilities, including restraint management.</p> <p>In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training was provided. The staff restraint competencies are current.</p>

		The Oceania national restraint authority group annual meeting was conducted in February 2016 and the meeting minute's evidence discussion and evidence of data around Oceania progress in reducing restraint usage nationally.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>The complaints register showed entries of four complaints. The complaints register included the date of the complaint, a heading with a short summary for the complaint, opportunity to record the resolution of the complaint, the date of this resolution and opportunity to record the review and outcome of the complaint. Interviews with family referred to complaints that were not included in the complaints register. The service’s records provider a list of steps to be taken during the resolution of completints with the opportunity for the person to identify when these steps are taken (for example; acknowledgement of the complaint, investigation of the complaints, continued contact with the complainant and more).</p>	<p>i) Not all complaints are recorded.</p> <p>ii) Steps taken in the resolution process were not specific documentation to evidence the process</p> <p>iii) 2/4 recorded, did not have reviews recorded.</p> <p>iv) 4/4</p>	<p>i) All complaints to be recorded.</p> <p>ii) To have documented evidence of the steps taken during resolution process.</p> <p>iii) All complaints to have reviews documented.</p> <p>iv) All complaints to have closing dates documented.</p>

			complaints recorded did not have closing dates/outcomes documented.	90 days
<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	PA Low	Personal items of clothing are going missing and the service is not able to track/find the missing items.	Personal items of clothing are going missing and the service is not able to track/find the missing items.	<p>The service has to implement, test and monitor processes to ensure residents clothing is cared for in a safe and appropriate manner.</p> <p>180 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Moderate	Interviews with families confirmed a lack of communication with service providers and incident and accident records do not consistently identify persons notified.	<p>i) Family interviews confirmed a lack of communication with service providers.</p> <p>ii) Incident and accident records do not consistently identify persons communicated with/notified.</p>	<p>i) To ensure full, frank and open disclosure relating to matters regarding residents, for example incidents, accidents and complaints that residents may have.</p> <p>ii) Incident and accident records to reflect persons communicated</p>

				with/notified. 60 days
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	Not all meeting minutes are comprehensive enough to reflect the content and outcomes of the meeting.	Registered nurses meeting, infection control meetings and residents meetings minutes are lacking information.	<p>The service to use templates provided by the organisation for recording meeting minutes to ensure core information is included.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Moderate	The service has a process in place for measuring achievements against the quality management plan. Incidents/accidents and internal audits are not consistently providing appropriate corrective actions plans.	<p>i) Follow-up actions do not consistently relate to the issue/problems.</p> <p>ii) The person responsible for implementation of the corrective action is not consistently identified.</p> <p>iii) Timeframes for implementing corrective actions is not consistently</p>	<p>i) Follow-up actions relating to incidents/accident and internal audits to relate to the identified problem.</p> <p>ii) Incident/accident documentation and internal audits to identify and record the persons responsible for implementing the corrective actions.</p>

			recorded.	iii) To identify and record appropriate timeframes for corrective actions. 180 days
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Staff make entries to the progress notes and other records of care. Not all entries in the residents' daily record show evidence of the name or designation of the service provider.	Names and designations of registered nurses, health care assistants and diversional therapists are not consistently recorded in clinical files of residents.	All designations to be consistently recorded in clinical files. 180 days
Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.	PA Low	Interview with the ICN confirmed they provide education in IC for staff. The interview also confirmed they have not conducted any relevant IC education to their role	The ICN has not completed relevant IC education specific to their role.	Provide evidence the ICN has completed relevant IC education specific to their role. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.