

# Oceania Care Company Limited - Elderslea Rest Home

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Elderslea Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 3 May 2016      End date: 4 May 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	102

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

This certification audit was undertaken to monitor compliance with the Health and Disability Service Standards and the district health board contract. Elderslea Rest Home is operated by the Oceania Care Company limited.

The service provides care for rest home, hospital and dementia residents. Occupation on the day of the audit was 102 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.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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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, were accessible. This information is given to residents' and their families on admission to the facility. Residents and family interviewed confirmed their rights are met and

consent forms are provided. The business care manager is responsible for management of all complaints. Interviews confirmed that staff are respectful of residents needs and communication is appropriate.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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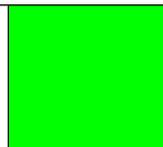
Oceania Care Company Limited is the governing body and is responsible for the service provided at Elderslea Rest Home. The business and care manager is appropriately qualified and experienced. There are two clinical leaders responsible for oversight of clinical care. Quality improvement data is collected, collated, analysed and reported through the use of the national quality system. Risks are identified and the hazard register is up to date. Adverse events are documented on incident and accident forms and areas requiring improvement are identified.

Policies and procedures relating to human resources management processes govern practices. Staff records reviewed provided evidence that human resources processes are followed. Staff education records confirmed in-service education is provided. A documented rationale for determining staffing levels and skill mix is implemented to reflect the resident's acuity to ensure the correct allocation of nursing staff is applied.

The business and care manager and clinical leaders are available after hours, if required, for clinical support. Care staff, residents and family report that there are 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.

There is evidence that each stage of service provision is developed with resident and/or family input, in a timely manner and coordinated to promote continuity of service delivery. The residents and family interviewed confirm their input into assessments, care planning, care reviews and access to a typical range of life experiences and choices.

A sampling of residents' clinical files validates the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan. Planned activities are appropriate to the group setting. The residents and family interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

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

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

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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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. The onsite laundry facility provides a full linen service for the facility. Chemicals, linen and equipment are safely stored. The service has a current building warrant of fitness which expires in August 2016. The preventative and reactive maintenance programme includes equipment and electrical checks.

## Restraint minimisation and safe practice

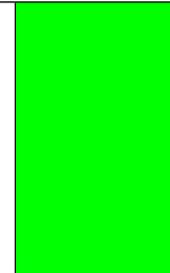
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has documented policies and procedures for restraint minimisation and safe practice. Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The restraint coordinators confirm that enabler use is voluntary.

The residents' files demonstrate that the service focuses on de-escalation processes. All residents in the dementia unit have 24-hour challenging behaviour management plans to ensure their behaviour is managed in an appropriate manner.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

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, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

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.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	50	0	0	0	0	0
<b>Criteria</b>	0	101	0	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff received education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service. Induction and orientation forms part of their annual mandatory education programme. Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice especially regarding maintaining of residents' privacy, providing residents with choices, encouraging independence.</p> <p>The information pack provided to residents on entry includes information on how to make a complaint and brochures on the Code advocacy services. Care staff are 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 business and care manager and clinical leaders report</p>

		<p>informed consent is discussed and recorded at the time the resident is admitted to the facility.</p> <p>Family interviews confirmed they have been made aware of and understand the principles of informed consent. The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files noted that all had appropriately signed advanced directives. The general practitioner makes a clinical decision regarding resuscitation for residents who are not able to make an advance directive (and have no advance directive documented in the past). The advance directive is discussed with the family and/or enduring power of attorney (EPOA) prior to the doctor signing the form.</p> <p>Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>The service has policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. 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. Family confirmed this information was included in the information package they received on admission. The nationwide advocate's 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 independently with family or on the van outings. Visitors' policy and guidelines are available to ensure resident safety and well-being is not compromised by visitors to the service. Residents' activity records reviewed demonstrated inclusion in 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,</p>	FA	<p>The service has systems in place to manage the complaints processes. The complaints process records a summary of the complaints, the investigation, outcome and other processes of complaints management.</p>

<p>respected, and upheld.</p>		<p>All complaints have resolution and documentation to support closure.</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. Residents and family interviewed confirmed having an understanding and awareness of these processes.</p> <p>Resident meetings are held monthly and residents and their families are able to raise any issues they have during these meetings, confirmed during interviews. A number of projects have been completed as a result of identifying shortfalls through complaints, adverse events monitoring and suggestions from residents.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. The initial and on-going assessment gains details of people's beliefs and values with care plans completed with the resident and family member. The residents' personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings. Staff receive training on abuse and 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; 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 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and</p>	<p>FA</p>	<p>The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. The initial and on-going assessment gains details of people's beliefs and values with care plans completed with the resident and family member.</p>

independence.		The residents' personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings. Staff receive training on abuse and 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; 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>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Māori health plan describes that the holistic view of Māori health is to be incorporated into the delivery of services. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. Access to Māori support and advocacy services is available if required from a local provider of health and social services.</p> <p>Staff members also provide cultural advice and support for staff if required. A cultural assessment is completed as part of the care plan for all residents. Specific cultural needs are identified in the residents' care plans and this was sighted in files reviewed. Staff were aware of the importance of family/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>	FA	Documentation provided evidence that 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. 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>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Oceania's policies and procedures outline processes to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct.</p> <p>Staff files reviewed included copies of 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. 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 behaviour.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has systems in place to ensure staff receive a range of opportunities which promote good practice within the facility. Education is provided by specialist educators as part of the in-service education programme which is overseen by the business and care manager with input from two clinical leaders and the clinical quality manager.</p> <p>The clinical quality manager, the business and care manager, the clinical leaders and registered nurses 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>	FA	<p>Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and families. The residents' files reviewed provided evidence that communication with family members is documented in residents' records. There is 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 through the district health board, if required. Some residents who require interpreter services have this provided by families and a volunteer from the community for a Russian resident provides interpreter services. Residents interviewed confirmed that they are aware of the staff that are responsible for their care and staff communicate well with them. Admission agreements reviewed were signed and dated on admission.</p>
<p>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>	FA	<p>The Oceania Care Company Limited's vision, values, mission statement and philosophy are displayed at the entrance to the facility, information in booklets and in staff training, provided annually.</p> <p>The organisation records their scope, direction and goals in their business, strategic and quality plans. The business and care manager provides monthly reports to the support office. Business status reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes and clinical indicators.</p> <p>The service has a business and care manager, supported by two clinical leaders and a clinical quality manager. The clinical leaders are employed in full time positions to work with the business and care manager and have responsibility for all clinical matters. The business and care manager has a current annual practising certificate, completed the Oceania management training and has been in the role for ten years.</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 if the business and care manager (BCM) and/clinical leaders (CL) are absent. Where possible the BCM and CL's are not scheduled leave at the same times. The CLs with support of the clinical quality manager provides cover when the business and care manager is absent. Support is also provided by the regional operations manager from the support office. The BCM 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</p>	FA	<p>Elderslea Lodge uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice.</p> <p>The service implements organisational policies and procedures to</p>

<p>quality improvement principles.</p>		<p>support service delivery. All policies are subject to reviews as required, with all policies current. Head office reviews all policies, with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to say that they have read and understood.</p> <p>A quality improvement plan with quality objectives was reviewed. These are used to guide the quality programme. 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 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. Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme, with corrective action plans documented and evidence of resolution of issues completed. There is documentation that includes collection, collation, and identification of trends and analysis of data.</p> <p>There are a variety of meetings held to discuss data. These include monthly staff/quality meetings, clinical meetings and health and safety meetings. Meeting minutes evidence communication with all staff around all aspects of quality improvement and risk management. There are also two monthly resident meetings that keep residents informed of any changes. Staff report that they are kept informed of quality improvements and can have input into discussions and review of service delivery.</p> <p>Meetings are held monthly. All meetings have an agenda and minutes are maintained with the identification of people responsible for outcomes and timeframes. Clinical indicators and quality improvement data are recorded and staff are informed at staff meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>The business and care manager is aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility, unexpected deaths, sentinel events,</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>infectious disease outbreaks, and changes in key managers.</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 with input from the clinical leaders. Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed, with evidence of improvements put in place. Incident and accident records include pressure injuries (refer 1.3.3.3). Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events. The service follows the Oceania policy regarding the management of incident and accidents.</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 and implemented. 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 orientation and induction records and competency assessments.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The BCM advised that staff are orientated at the beginning of their employment. 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. Annual competencies are completed by care staff.</p> <p>The registered nurses (RN) and business and care manager (BCM) hold current annual practising certificates along with other health practitioners involved in the service. The BCM is responsible for the in-service education programme. Clinical competencies were reviewed and current. Staff are supported to complete education through external education providers. An annual performance appraisal schedule is in</p>

		<p>place and current staff appraisals were sighted on all staff files reviewed.</p> <p>The service has an annual training schedule. Staff attendances of training sessions are documented. Education and training hours are at least eight hours a year, for each staff member, with the RNs training records indicating that they have had well in excess of eight hours training in the past year around clinical topics, for example, wound management, management of challenging behaviour and de-escalation and continence.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. There are 115 staff, including the management team, clinical staff, a diversional therapist and activity staff, and household staff. Rosters were reviewed and there is sufficient staff cover to provide the services.</p> <p>Registered nurse (RN) cover is provided 24 hours a day. There are clinical leaders on duty seven days a week to support the RNs, including after hour on-call. Health care assistants and family interviewed reported there are adequate staff available. Resident and family interviews confirm that services meet their needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Resident information was entered in an accurate and timely manner into a register on the day of admission, using the 'Peoples Point' system. Resident files are integrated and recent resident information is located in residents' files. Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including designation. Approved abbreviations are listed.</p> <p>Residents' information is stored securely in staff areas. Clinical notes are current and accessible to all clinical staff, information containing sensitive resident information is not displayed in a way that it could be viewed by other resident's medical care or members of the public.</p> <p>Individual resident files demonstrate service integration. 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 confirm 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>When the need for service is identified, it is planned, coordinated and delivered in timely and appropriate manner. Information about the service is accessible and includes details of the services provided, its location and how the service is accessed. Residents' files reviewed contained compliance with entry criteria. Signed admission agreements meet contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and coordinated 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.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy and procedures identify all aspects of medicine management. Medicine charts evidence: residents' photo identification; legibility; as required (PRN) medication is identified for individual residents and correctly prescribed; three monthly medicine reviews are conducted; and discontinued medicines are dated and signed by the GPs. The residents' medicine charts record all medications a resident is taking (including name, dose, frequency and route to be given).</p> <p>A safe system for medicine management was observed on the days of the audit. The staff observed demonstrated knowledge and understanding of their roles and responsibilities relating to each stage of medicine management. All staff who administer medicines complete annual medication competencies, with all competencies current. Training and education in medication management occurred in 2015.</p> <p>Controlled drugs are stored in separate locked cupboards in the rest home and the hospital wings. The controlled drug register evidences weekly checks and six monthly stock takes and accurate records.</p> <p>The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>Residents' who request to self-administer medicines do so according to policy.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food, fluid and nutritional requirements of the residents are provided in line with recognised nutritional guidelines for older people and menus are reviewed by the dietitian. The residents have a choice of two lunch and two dinner options. The residents' choices are obtained by staff and communicated to the kitchen to allow time for menu preparation. If the dietary requirements are not covered by the available meal options, the kitchen staff will provide an alternative meal as per the dietary requirement form for that resident.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the chef and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>The aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.</p> <p>There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.</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>	<p>FA</p>	<p>There is a process for informing residents, their family/whanau and their referrers if entry to the service 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. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	<p>FA</p>	<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</p>

gathered and recorded in a timely manner.		resident; 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. 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.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The assessment findings form the resident's care plan. The care plans reviewed record required support the resident needs to meet their goals and desired outcomes. The care plans evidence input from the resident and/or family members and other staff involved the care of the resident. Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written.
<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	The residents' care plans evidence detailed interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records are current. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirm they are familiar with the current interventions of the residents they were allocated.
<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	In interview, the diversional therapist (DT) confirmed the activities programmes meet the needs of the service group and the service has appropriate equipment. There are eight activities staff, including one trained DT who plan, implement and review the activities programmes. There is internal and external collegial support in place for the activities staff. There are four activities programmes at the facility: one for the rest home residents; two programmes for the hospital residents (due to two hospital wings) and one programme for residents with dementia. The activities programme in the dementia wing is provided Monday to Sunday. Along with the activities staff, the health care assistants in the dementia unit implement individual residents' activities. Interviews with health care assistants confirmed this. The 24 hour activities care plans

		<p>for the residents' with dementia are detailed and individualised.</p> <p>The activities programmes include exercises and outings for those residents able to partake. The activities programmes also 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' activities attendance records are maintained. The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programme.</p> <p>A café has been set up at the facility to encourage residents to socialise at afternoon tea time. This has been received positively by the residents and family members.</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.</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, a short term care plan is completed. Short term care plans are reviewed as indicated by the degree of risk noted during the assessment process. Interviews, verified residents and family/whānau are included and informed of all changes.</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 or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. All referrals are documented in resident's clinical files.</p> <p>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</p>	FA	<p>Documented processes for the management of waste and hazardous</p>

<p><b>Substances</b></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>		<p>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 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><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed; the date of expiry is 31 August 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 two courtyards and lawn areas with shade, seating and outdoor tables. The service has a secure unit for residents identified as requiring dementia care. Access into the service is through touch pads and key pads are used to exit the unit.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></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>FA</p>	<p>There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members report that there are sufficient toilets and showers with some rooms in the rest home/hospital area having their</p>

		own ensuite. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></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 was 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><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has lounges and dining areas including areas that can be used for activities. All 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><b>Standard 1.4.6: Cleaning And Laundry Services</b></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>The laundry services are completed on site. 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. The linen trolleys are clearly labelled to identify resident's individual laundry and general laundry. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. Cleaners were observed on the days of the audit 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.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>An evacuation plan was approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff, six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including: food; water; blankets; emergency lighting and gas BBQs. An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways, dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells.</p> <p>External doors leading to the gardens are locked after sunset. 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>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever possible. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area for residents. Family and residents confirm that rooms are maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control (IC) policy and procedures provide information and resources to inform staff on infection prevention and control.</p> <p>The delegation of IC matters is documented in policies, along with an infection control nurse's (ICN) job description. The ICN is a RN. There is evidence of regular reports on infection related issues and these are communicated to staff and management. The IC programme is reviewed annually.</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</p>	<p>FA</p>	<p>The ICN has access to relevant and current information which is appropriate to the size and complexity of the service, including but not limited to: IC manual; internet; access to experts; and education. The IC</p>

the organisation.		is an agenda item at the facility's meetings, evidenced during review of meeting minutes and interviews with staff.
<p><b>Standard 3.3: Policies and procedures</b></p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	The IC policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain an appropriate level of information and are readily accessible to all personnel, confirmed at staff interviews. The IC policies and procedures are developed and reviewed regularly in consultation and input from relevant staff and external specialists. IC policies and procedures identify links to other documentation in the facility
<p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The IC education is provided to all staff, as part of their orientation and as part of the on-going in-service education programme. In interviews, staff advised that clinical staff identify situations where IC education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted. The IC staff education is provided by the ICN, clinical leaders, RNs and external specialists. 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.
<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The ICN is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at monthly general staff meetings.</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short term care plans in place.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the clinical leaders, charge nurses, RNs, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handovers and review of the residents' files.</p> <p>A quality improvement project was conducted focusing on fungal</p>

		infections during summer months with reduction of the same as a result of implementation of staff education and regular podiatrist visits.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is documented and implemented. There were four residents at the facility using enablers and five residents using restraint. The restraint and enabler use is recorded in residents' care plans.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.</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 is provided. The staff restraint competencies are current.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The facility has a process for determining approval of all types of restraint used. The two clinical leaders share the responsibility of the restraint coordinator's role and complete a restraint assessment prior to commencement of any restraint. The restraint approval group is defined in the restraint minimisation and safety policies and procedures.</p> <p>Health care assistants are responsible for monitoring and completing restraint forms when the restraints are in use. Evidence of ongoing education regarding restraint and challenging behaviours is evident</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Restraint assessments include assessment of appropriate factors relating to the use of restraint as defined by the standard.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Strategies are implemented prior to use of restraint to prevent the resident from incurring injury, for example, the use of low beds; mattresses and sensor mats. Restraint consents are signed by appropriate staff and family/resident.</p> <p>Restraints are recorded in the care plans and reviewed along with the care plan reviews. The restraint register is up to date and records all</p>

		necessary information.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Each episode of restraint is evaluated. The resident (if able) and the family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. The restraint committee meet every two months and evaluate the all restraint use. There was evidence of two residents who no longer required restraint following evaluation and implementation of other strategies.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>An Oceania National Restraint Authority Group meeting was conducted in February 2016. The meeting minutes record: the approval of types of restraint; extent of restraint use; trends identified across Oceania Health care facilities; progress in reducing restraint nationally; adverse outcomes from restraint interventions; staff compliance with restraint programme policies and protocols; and restraint practices and staff knowledge and competency in relation to restraint.</p> <p>Quality improvement project on restraints was conducted from May 2013 to October 2015 and evidences the use of restraint throughout Oceania facilities has reduced.</p> <p>There is evidence of monitoring and quality review of use of restraints at the facility.</p>

## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.