

Oceania Care Company Limited - Holmwood 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:	Holmwood Rest Home
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 May 2016 End date: 13 May 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:	54

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 Services Standards and the District Health Board contract. Holmwood Rest Home is operated by Oceania Care Company Limited. The service includes a rest home and hospital.

Holmwood Rest Home can provide care for up to 56 residents. On the days of this audit there were 54 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. There is one requirement for improvement relating to the quality management system.

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.	Green	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 of Rights), 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 interviews confirmed that staff are respectful of their needs and communication is appropriate.

Residents and family interviewed confirmed consent forms are provided. Staff members confirm that time is provided if any discussions and explanations are required. The business and care manager is responsible for management of all complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Oceania Care Company Limited is the governing body and is responsible for the service provided at Holmwood Rest Home. The business and care manager is appropriately qualified and experienced. The clinical manager is responsible for oversight of clinical care. HealthCERT received notification of this appointment.

Quality improvement data is collected, collated, analysed and reported through the use of their national quality system. Corrective action plans are developed and address areas identified as requiring improvement. 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 their practices. Staff records reviewed provide evidence that their human resources processes are followed. 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 professional bodies.

A documented rationale for determining staffing levels and skill mix was reviewed. The service uses the Peoples point document control system.

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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The organisation works with the Needs Assessment Coordination Service to ensure access to the service is efficient with all relevant information available for the resident and their family, prior to and on admission.

Residents' needs are assessed on admission by a registered nurse. Residents' files provide evidence that residents' needs, goals and outcomes are identified. Nursing evaluations are documented, resident focused and indicate progress towards meeting the desired outcomes. Where the progress of a resident is different from the expected, the service responds by initiating changes to the long term care plan or recording this on a short term care plan. Family have opportunity to contribute to the development and evaluation of care plans. Residents and families interviewed report satisfaction with the services provided.

An activities programme includes a wide range of activities and involvement with the wider community. Individual activities are provided either within group settings or on a one-on-one basis.

The medicine management policies and procedures guide staff practice. Staff responsible for medicines management complete annual competencies. The residents self-administering medicines do so according to policy.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines. Residents' special dietary requirements, need for feeding assistance or modified equipment are met.

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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The service provides adequate toilet and bathing facilities. Visual inspection evidences that all bedrooms are large and adequate personal space is provided throughout the service. The service complete fire drills in order to ensure staff are familiar with the process of evacuation. Ventilation is provided through heat pumps, heat in bedrooms is provided through the use of radiator heaters in the hospital and panel heaters in the rest home.

The facility has an escalation 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. The service has a current building warrant of fitness. The preventative and reactive maintenance programme includes hot water checks, 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.

Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. On audit days, there were nine residents using restraints and one resident requesting the use of an enabler.

Staff education in restraint, de-escalation and challenging behaviour is provided at orientation of new staff and through the in-service programme.

Infection prevention and control

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

The infection prevention and control programme is reviewed annually. An infection control nurse is responsible for the programme, including education and surveillance.

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)
Standards	0	49	0	1	0	0	0
Criteria	0	100	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: 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 form 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.</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 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 reported informed consent is discussed and recorded at the time the resident is admitted to the facility. Staff interviewed demonstrated a good understanding of informed consent processes.</p> <p>Residents and family interviewed confirmed they have been made aware of and understand the</p>

		principles of informed consent. Residents/family are provided with various consent forms on admission for completion, as appropriate, and these were reviewed in resident's files. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these were reviewed in resident's files.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	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. Residents and family interviewed confirmed that advocacy information was included in the information package they received on admission. Observations provided evidence the nationwide advocate details are displayed along with advocacy information brochures. Admission information was reviewed and provided evidence advocacy, complaints and information on the Code is included.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and family members interviewed confirmed they can have access to visitors of their choice. The service has a van available to take residents on community visits and outings. Some residents go out independently on a regular basis. 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.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The business and care manager is responsible for complaints. The service has appropriate systems in place to manage the complaints processes. The service records complaints, the investigation of complaints, the resolutions, including acknowledgement of receiving the complaint, and a closing letter addressed to the complainant with a closing-out date and sign-off. The business and care manager advised there have been no complaints to the Health and Disability Commissioner, the district health board (DHB), Accident Compensation Corporation (ACC), coroner or HealthCERT since the previous audit at this facility. 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 displayed and the complaints register was up-to-date. Residents and family interviewed confirmed having an understanding and awareness of these processes. Resident meetings are held bi-monthly and residents are able to raise any issues they have during these meetings,

		confirmed during interviews. 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 Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), and information on the advocacy service are available and displayed throughout the service. The admission information packs were reviewed and included information on the Code, advocacy and complaints processes. Residents and 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 agreement and admission agreements. Residents interviewed confirmed they had access to an advocate if needed. The completed resident and family survey questionnaires indicated residents 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>	FA	<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. This was confirmed during review of the completed satisfaction survey questionnaires. Interview with the general practitioner (GP) confirms not having any concerns relating to abuse and neglect of residents.</p> <p>Activities in the community are encouraged and the business and care manager advised that some of the residents attend community events independently. 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 that respects and acknowledges</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. Staff members also provide cultural advice and support 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 are aware of the importance of whānau in the delivery of care for the Māori residents.</p>

their individual and cultural, values and beliefs.		Whānau are able to be involved in the care of their family members.
<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	<p>Documentation provided evidence that appropriate culturally safe practices were 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 had no 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>	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, which were reviewed on staff files. 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>	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 the clinical manager and the regional clinical quality manager. The clinical quality manager, the business and care manager and the clinical manager 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</p>

		<p>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 policies and procedures were in place to ensure staff maintain open, transparent communication with residents and their families in both the rest home and the dementia unit. 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. 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 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 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 relating to governance through the Oceania intranet. Governance reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators, as sighted.</p> <p>The service has a business and care manager, supported by a clinical manager and clinical quality manager. The clinical manager/registered nurse (RN) is employed in a full time position to work with the business and care manager and has responsibility for the management of compliance with all clinical matters. The clinical manager's appointment was confirmed with HealthCERT; the auditors sighted a copy of the notification.</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</p>	FA	<p>The business and care manager is an experienced registered nurse who has worked in management roles in the aged care sector over the previous ten years. The business and care manager was appointed to their current position in March 2015. The business and care manager completed two papers relating to organisational management at the University of Waikato.</p> <p>There are appropriate systems in place to ensure the day-to-day operation of the service</p>

<p>consumers.</p>		<p>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 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>	<p>FA</p>	<p>A quality improvement plan with quality objectives, including a quality and risk management plan and business plan were reviewed. These are used to guide the quality programme and include goals and objectives. Completed internal audits for 2016 were reviewed. Family, resident and staff satisfaction surveys are completed as part of the audit programme and collated results for surveys were reviewed.</p> <p>Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures. Monthly quality meetings are held. Resident meetings are held bi-monthly. Meeting minutes reviewed provided evidence of reporting/feedback on completion of internal audits and various clinical indicators.</p> <p>Clinical indicators and quality improvement data is recorded and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed, evaluated and reported. There was evidence this information is being reported to staff at staff meetings.</p> <p>Quality improvement data reviewed, including meeting minutes provided evidence that corrective action plans are being developed, implemented, monitored and signed off (refer to 1.2.4.3).</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies/procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed during interviews that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p> <p>There is a document control system to manage the policies and procedures. This system documents approved, update and manage the use of obsolete documents. Key components of service delivery are linked to the quality management system. Quality improvement data and risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of the risk.</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>PA Low</p>	<p>Staff document adverse, unplanned or untoward events on an accident/incident form. Families are informed after adverse events, confirmed in clinical records and during family and resident interviews. Accident and incident forms are reviewed and signed off by the business and care manager. Corrective action plans address areas requiring improvement and were documented, however all aspects of the incident/accident records are not consistently completed.</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions and policies and procedures. Policy and procedures comply with essential notification reporting for example, health and safety, human resources, infection control and pressure injury notifications.</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 competency assessments.</p> <p>Copies of annual practising certificates were reviewed for all staff that require them to practice and are current. The business and care 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 training and education via their internal and external education providers. The internal training programme provides compulsory and other training for all staff regarding a variety of care topics. Training includes competency testing for clinical staff.</p> <p>Staff members who require registration with professional bodies have current annual practicing certificates. Care staff interviewed confirmed they have completed an orientation, including competency assessments. 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. An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. Employment records include application forms, CVs, orientation and induction processes, training records, professional registration, job descriptions, first aid training and police vetting. An appraisal schedule is in place and current annual staff appraisals were sighted on all staff files reviewed.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided 24 hours a day. On call after hours RN support and advice is provided by the clinical manager and a senior RN. The minimum amount of staff on duty is during the night and consists of one RN and three caregivers.</p> <p>Care staff interviewed reported there are adequate staff available and that they are able to get through their work. 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. Rosters were reviewed and staffing meets the ratios as described in the Oceania staffing and staffing ratios rationale.</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>FA</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 was located in residents' files. Resident files reviewed provided evidence that entries into the residents' clinical record include the time of entry, the date and entries are dated. Approved abbreviations are listed. Designations of service providers are clear and identifiable.</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 medicines/script folder stored with medication. The resident's national health index (NHI) number, name, date of birth and GP are used as the unique identifier. Resident information is secure and private. 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 had been identified, it is planned, coordinated and delivered in a timely and appropriate manner. Information about the service is accessible and includes: details of the services provided; its location; hours; how the service is accessed; and identifies the process if a resident requires a change in the care provided.</p> <p>There are pre-entry screening processes, ensuring 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. All referrals are documented in the progress notes.</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>Medication areas, including controlled drug storage evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded.</p> <p>All staff authorised to administer medicines have current competencies. The medication rounds were observed and evidenced that staff members were knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.</p> <p>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). The residents self-administering medicines at the facility 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>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 cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>All 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 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</p>

		airy.
<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>There is a process for informing residents, their family and referrers, if entry is declined. The reason for declining entry would be communicated to all concerned in a timely manner. Where requested, assistance would be given to provide the resident and their family with other options for alternative residential services.</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; the resident; family 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 present if requested.</p> <p>Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated.</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>The assessment findings are documented in the residents' care plans. The required support the resident needs to meet their goals and desired outcomes is included in the care plan. 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>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 confirm 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 resident they are allocated.</p> <p>The service has sufficient supplies of equipment available to comply with best practice guidelines and meet the residents' needs.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Family and friends are welcome to attend activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.</p> <p>Interviews with residents and family members verify feedback relating to activities is sought and there is satisfaction with the activities offered.</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, the service is seen to respond by initiating changes to the service delivery 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. Interviews, verified residents and family 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 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. 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</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place</p>

<p>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>		<p>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 and the date of expiry is 20 June 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. 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 grass areas with shade, seating and outdoor tables.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	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 facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</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 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</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</p>

<p>personal space/bed areas appropriate to the consumer group and setting.</p>		<p>personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own. There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required. The facility has specified areas for safe storage of wheelchairs.</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>	<p>FA</p>	<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 enables residents to mobilise freely. The dining areas have ample space for residents. Residents can choose to have their meals in their room.</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>	<p>FA</p>	<p>Laundry services are completed on the premises. 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 that the laundry is well managed. 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 cleaning trolley must be with them at all times. Cleaners were observed on the days of the audit in the hospital keeping the cleaning trolley in sight.</p> <p>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>
<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 most recent drill took place on 19 April 2016. 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. 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.</p>

		<p>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. 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>The doors are locked in the evenings. Staff complete a check in the evening that confirmed that security measures had been put 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. 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>	FA	<p>The infection control (IC) policies 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, terms of references and the infection control nurse's (ICN) job description. The ICN is the clinical manager/registered nurse (RN). There is evidence of regular reports on infection related issues and these are communicated to staff, management and the Oceania support office. 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 the organisation.</p>	FA	<p>The ICN takes the leadership role in the infection control team. IC is part of the health and safety and quality team meetings. The ICN has access to relevant and current information, which is appropriate to the size and complexity of the service. There is evidence of communication with nurse specialists in respect of IC matters. IC is an agenda item at the facility's meetings, evidenced during review of meeting minutes and interviews with staff.</p> <p>Implementation of the IC programme is monitored via internal audits that include review of procedural compliance, staff knowledge and training and IC documentation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for</p>	FA	<p>The IC policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at</p>

<p>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>staff interviews. The IC policies and procedures are developed and reviewed annually in consultation and input from relevant staff, and external specialists. 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>FA</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. 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, RNs and external specialists. The ICN has attended training and education relating to IC. 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>
<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 IC nurse is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at facility's meetings. 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 are diagnosed with an infection have short term care plans.</p> <p>All infections are entered into the clinical indicators log. These are reviewed by Oceania clinical and quality team and reported to the Oceania boards on monthly basis.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the CM, RNs, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interview, the ICN confirmed an outbreak occurred at the facility in November 2015. There is evidence of implementation of appropriate strategies to minimise the outbreak and consultation with the IC nurse specialist. As this was a respiratory outbreak, no notification to authorities was required.</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. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded and implemented. There was one resident at the facility using an enabler and nine residents using restraints on the days of the audit. The restraint and enabler use are documented 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 clinical staff and in staff records there is evidence that restraint minimisation and safe practice, enabler use and prevention and/or de-escalation of challenging behaviour education and training is provided. The staff competencies in restraint use 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>	<p>FA</p>	<p>The Oceania Care Company national restraint authority group are responsible for approving any form or type of restraint practice used at Oceania facilities nationally. Oversight of restraint use at each individual Oceania facility is the responsibility of the business and care managers and restraint coordinators. The restraint coordinator at Holmwood Rest Home is the clinical manager (RN). The responsibilities for this role are defined in the position description. The restraint coordinator has completed training in restraint minimisation and restraint management relevant to their role.</p> <p>Use of restraint is authorised following a comprehensive assessment of the resident. The approval includes consultation with other members of the multidisciplinary team. The restraint consent forms evidence consent for the use of restraint is obtained from the GP, restraint coordinator and the resident and/or a family member.</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>	<p>FA</p>	<p>Restraint assessment is completed prior to commencement of any restraint. The clinical files of residents using restraint evidence the restraint assessment authorisation and plans are in place. Restraint assessments evidence the restraint coordinator's sign off and evidence all appropriate factors have been taken into consideration.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Protocols on safe use of restraint record the processes of assessment, approval and implementation and these guide staff in the safe use of restraint. Strategies are implemented prior to the use of restraint to prevent the resident from incurring injury, for example, the use of</p>

		<p>low beds; mattresses and sensor mats. The policies that guide staff in the safe use of restraint document: the current approved forms of restraint; the indications for use; associated risks; safety precautions; and required authorisation, reporting and monitoring. There have been no adverse outcomes or sentinel events relating to restraint use reported to the Oceania support office.</p> <p>Staff training and education in restraint use is conducted at orientation and at mandatory ongoing education sessions. Evidence of ongoing education regarding restraint and challenging behaviours is evident. Restraint competency testing of clinical staff is included in the education of staff.</p> <p>The restraint register is up to date and records all necessary information to provide an auditable trail of restraint events.</p> <p>Health care assistants are responsible for monitoring and completing restraint forms when the restraints are in use and report any relevant restraint issues to registered nurses, confirmed in interviews and review of monitoring forms.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Restraint use is reported monthly by the facility to the Oceania support office. The clinical files of residents using restraint evidence the restraint evaluation forms are completed and these include all the relevant factors in this standard. The restraint minimisation team meeting minutes record evaluation of each restraint use at the facility on a monthly basis.</p> <p>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.</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>There is evidence of monitoring and quality review of the use of restraints at the facility. The restraint minimisation team meeting minutes evidence review of the compliance with the standard and include: individual resident's restraint review; restraint register update; staff education review and any relevant restraint issues. Restraint meetings are held monthly. Internal audits on restraint use are conducted and include detailed review of clinical files of residents who use restraint.</p> <p>Oceania national restraint authority group terms of reference are recorded in the policy. This group meet annually to review the compliance with the restraint standard and review of restraint use nationally. National restraint benchmarking and analysis is reviewed monthly by the clinical and quality managers and the results indicate there has been reduction in restraint used</p>

		nationally due to use of low/low beds and the use of perimeter mattress surrounds.
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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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Incident/accident records are completed for all adverse events and the service inform family, the manager and, when needed, the GP of events. The incident/accident reporting process includes investigation of all incidents and accidents, identifying corrective actions and the form provides opportunity for staff members to identify and record the person responsible for the implementation of the corrective action. The form also provides opportunity to identify timeframes for the implementation of the corrective actions, however not all persons responsible and timeframes for implementation of corrective actions are recorded.</p>	<p>Incident/accident records provide opportunity for: i) the identification of the person responsible and ii) recording of required timeframes for the implementation of corrective actions; however records do not consistently include this information.</p>	<p>Incident/accident records to consistently include i) identification of the person responsible for the implementation of corrective actions as well as the ii) timeframes for implementation to be recorded at all times.</p> <p>180 days</p>

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.