

Oceania Care Company Limited - Gracelands Rest Home and Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Oceania Care Company Limited
Premises audited:	Gracelands Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 June 2016 End date: 30 June 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:	85



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

This certification audit was undertaken to monitor compliance with the Health and Disability Service Standards and the district health board contract. Gracelands Rest Home and Hospital is operated by the Oceania Care Company. The audit process included review of policies and procedures, sampling of residents and staff files, observations and interviews with residents, family/whanāu.

The service provides for rest home and hospital level of care. Occupancy on the days of audit was 85.

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

An improvement is required in care planning.

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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Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family. Information on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights information (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is available. The business and care manager is responsible for management of complaints. Interviews with residents and families confirmed that staff are polite and respectful of residents needs and communication is appropriate. Interviews with staff confirmed an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		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 Gracelands Rest Home and Hospital. The business and care manager is qualified and experienced. Oceania has a documented quality and risk management system that supports the provision of clinical care and support at the service. Policies are reviewed at support office. Quality and risk performance is reported through meetings at the facility and is monitored by the organisation's management team through the business status reports and regional operations manager reports.

Quality improvement is monitored and bench marking reports include incident/accidents, infection, complaints and clinical indicators with trends analysed to improve service delivery.

There are human resource policies implemented relating to recruitment, selection, orientation and staff training. Professional qualifications were validated and registration with professional bodies was verified. A documented rationale for determining staffing levels and skill mix is implemented to reflect the resident's acuity. The service has an annual training plan to ensure ongoing training and education for all staff members. Care staff, residents and family report that there are adequate staff available. The business and care manager as well as the clinical manager are available after hours, if required.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Residents' needs are assessed on admission to the facility by completing risk assessments and initial care plans. There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and family confirm their input into assessment, care planning and care evaluations. Where progress is different from expected, the service responds by initiating changes to the long term care plan or recording the short term goals and interventions on a short term care plan.

Planned activities are appropriate to the group setting. The residents and family confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

There is a secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. The resident self-administering medicines does so according to policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Additional nutritional 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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The facility provides a physical environment specific to the needs of the residents. The physical environment reduces risks and promotes safety and independence for residents. Residents are provided with accessible and safe external areas. The service has a current building warrant of fitness, expiring in December 2017.

Restraint minimisation and safe practice

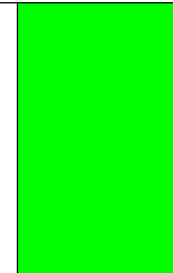
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

Staff education in restraint, de-escalation and challenging behaviour has been provided.

Infection prevention and control

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



Standards applicable to this service fully attained.

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

Infection control is a standard agenda item at facility's meetings. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully 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. This also forms part of their annual mandatory education programme. Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice especially regarding maintaining of residents' privacy, providing residents with choices and encouraging independence.</p> <p>The information pack provided to residents on entry includes information on how to make a complaint and access to 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</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. Residents and family interviewed confirmed they have been made aware of and understand the principles of informed consent. Residents/family are provided with various consent forms on admission for completion as appropriate and these were reviewed on</p>

and give informed consent.		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 on 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 facility has policies regarding advocacy/support services in place, including how to access independent advocates. Family interviewed confirmed that advocacy support is available to them, if required. Family confirmed receiving the information pack which includes the nationwide advocate's details. This was confirmed through review of an information pack during the onsite audit. The information pack includes information on the complaints process and the Code. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Staff training on the role of advocacy services is included in Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code)
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	The service has an open visiting policy. Family interviews confirmed residents have access to visitors of their choice. Residents go out independently with family. 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 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 service has systems in place to manage the complaints process. The complaints process records a summary of complaints, the investigation, outcome and other processes required to evaluate the complaint. Changes brought about by the complaints process contributed to quality improvements in services. Complaints reviewed had resolutions documented and were closed out. Residents meetings are held bi-monthly, where residents and their families are able to raise concerns or issues and meeting minutes confirmed the process.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	The Code and information on the advocacy service are available and displayed in English and Te Reo in the foyer and other areas in the facility. The admission information packs reviewed included information on the Code, advocacy and complaints processes. Interviews confirmed explanations

<p>Consumers are informed of their rights.</p>		<p>regarding their rights occurred on admission. The business and care manager (BCM) clinical manager (CM) and registered nurses (RNs) follow up with a discussion with residents and families during the admission process. 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. The completed resident and family surveys indicated residents are aware of their rights and are satisfied with this aspect of service delivery.</p> <p>Residents and family interviewed received copies of the Oceania handbook. Families and residents are informed of the scope of services. This is included in the service agreement and admission agreements.</p> <p>Residents interviewed confirmed they have access to an advocate who visits the service on a regular basis. The business and care manager advised that an advocate visits the facility on a regular basis and is also responsible for taking resident meetings.</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>	<p>FA</p>	<p>The organisation has a philosophy that promotes respect and dignity. 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 understood their professional boundaries. Residents were observed being treated with respect by care staff during this audit.</p> <p>Activities and outings in the community are encouraged, and are part of the resident's activities plan. Values, beliefs and cultural aspects of care are recorded in residents' clinical files reviewed. Interviews with staff confirmed they are able to identify signs and symptoms of abuse and know the reporting process for concerns relating to resident abuse, should this ever occur</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 their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The Māori health plan describes the view of Māori health and guides the organisation to implement services for Māori to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. Access to local kaumātua and advocacy services is available, if required from local providers of health and social services. Family/whanāu are involved in the care of their family members, this was confirmed in family/whanāu interviews.</p> <p>Staff members 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. Staff are aware of the importance of whanāu in the delivery of care for the Māori residents.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Documentation provided evidence that appropriate culturally safe practices are implemented and maintained, including respect for residents' cultural and spiritual values and beliefs. 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 and family/whānau interviewed confirmed their culture, values and beliefs are respected, and their spiritual needs are met. During interview, care staff demonstrated an understanding of cultural safety. Processes are in place for residents to have access to appropriate services, ensuring their cultural and spiritual values and beliefs are implemented.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Oceania's policies and procedures outline processes to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct..</p> <p>Staff files reviewed included copies of code of conduct policies, documents and training records on conflict of interest issues including the accepting of gifts and personal transactions with residents. Expected staff practice is outlined in job descriptions and employment contracts. Knowledge of these policies was confirmed in staff interviews.</p> <p>Review of the adverse events reporting system, complaints register and interview of the business and care manager indicates there have been no allegations made by residents of unacceptable behaviour by staff members. Residents and family interviewed reported that staff maintain appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has systems in place to ensure staff receive a range of opportunities which promote good practice within the facility. Education is provided both internally and externally to facilitate and ensure good practice. The in service education programme is managed by the clinical manager. There is a training programme for all staff. Managers are encouraged to complete management training. There are monthly regional management meetings. Specialised training and related competencies are in place for the registered nursing staff, with a review of staff files indicating that these are completed annually by all staff, relevant to their role. Residents and families reviewed expressed a high level of confidence and satisfaction with the care delivered.</p> <p>Documentation reviewed provided evidence that policies and procedures are based on evidence-</p>

		based rationales.
<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 required interpreter services in the past have had this provided by families and a volunteer from the community. Residents interviewed confirmed that they are aware of the staff that are responsible for their care and staff communicate effectively 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. The service has a business and care manager, supported by a clinical manager and supported by the clinical quality manager.</p> <p>The clinical manager's appointment is full time and responsible for all clinical matters. The clinical manager has worked for the organisation in a variety of roles. The business and care manager has a business management background, has been in this role for three years, and has recently been appointed as a regional operations manager.</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>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,</p>	FA	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the business and care manager (BCM) and/or the clinical manager (CM) be absent. The CM or the clinical quality manager stands in when the business and care manager is absent. Support is also provided by the regional operations manager and the senior clinical quality manager from the support office. The CM confirmed their responsibility and authority for this role.</p>

appropriate, and safe services to consumers.		
<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>	FA	<p>The Oceania Care Company policies guide their quality and risk management processes which support service delivery. All policies are reviewed by the support office, with input from clinical quality and the business and care managers. Policies are current and aligned with the Health and Disability Sector Standards, legislation, and best practice guidelines. Policies are available to staff in hard copy. New and revised policies are presented to staff at staff meetings.</p> <p>A quality improvement plan with quality objectives was reviewed during the onsite audit. These are used to guide the quality programme. Family/resident and staff satisfaction surveys are completed as part of their audit programme and collated results for surveys were reviewed.</p> <p>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, incidents and accidents, implementation of an internal audit programme, with corrective action plans documented and evidence of resolution of issues completed.</p> <p>The service has monthly staff/quality meetings and health and safety meetings. All meetings have an agenda and minutes are maintained with documentation supporting the timeframes and designated roles to implement any changes in practice and outcomes. Meeting minutes evidenced communication with staff, residents and families regarding all aspects of quality improvement. The service has a document control system to manage new and obsolete policies and procedures.</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>	FA	<p>The business and care manager is aware of situations in which the service would be required to report and notify statutory authorities, including police attending the facility, unexpected deaths, sentinel events, infectious disease outbreaks and changes in key management roles. Staff document adverse, unplanned or untoward events on an accident/incident form. This was confirmed in clinical records and during staff interviews. Incident and accident forms are reviewed and signed off by the business and care manager with input from the clinical manager and RNs. Incident reports had a corresponding note in the progress notes to inform staff of the incident. Incidents and accidents information is analysed, with corrective actions recorded. Incident and accident records include pressure injuries. Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events. The Oceania Care Company policies guide their quality and risk management processes which support service delivery.</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>The clinical manager and registered nurses (RN) hold current annual practicing certificates. There was evidence in the staff files that the contracted GP and the physiotherapist hold current practicing certificates. Staff have current annual performance appraisals on file. RNs are aware of their scope of practice and work within the guidelines of their scope.</p> <p>Staff files included appointment documentation, for example, signed contracts, job descriptions, reference checks, police checks and interviews. Annual competencies are completed by clinical staff, for example, competencies relating to hoist and oxygen use, hand washing, wound management, medication management, moving and handling, restraint, nebuliser use, blood sugar management and insulin administration. The organisation has a mandatory education and training programme. Staff attendances 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. The RN training programme includes clinical topics, for example, wound management, de-escalation and management of challenging behaviour as well as continence management. Contracted allied health professionals had current annual practicing certificates (APCs)</p> <p>All staff complete an orientation programme and health care assistants (HCAs) are paired with a senior HCA for several shifts or until they demonstrate competency in a number of tasks, including personal cares. HCAs confirmed their roles in supporting and buddying new staff.</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 and process in place to determine the services provider levels and skill mixes in order to provide a safe service.</p> <p>There are 90 staff, including the management team, clinical staff, diversional therapist, activities coordinators, physiotherapist, physiotherapists assistant, and housekeeping staff. There is a designated role for roster management and implementation. Rosters were reviewed and there is sufficient cover to provide the safe services. Registered nurse (RN) cover is provided 24 hours a day.</p> <p>There are clinical leaders who report to the clinical manager, support the RNs seven days per week, including after hour on-call duties. 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,</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place and the hazard register is current. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and 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. Interviews</p>

current, confidential, and accessible when required.		<p>with the household staff confirmed this.</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 1.3.1: 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>	FA	<p>When the need for service had been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner. Information about the service is accessible and includes all relevant information.</p> <p>There is a pre entry screening process, ensuring compliance with the facility's 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>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort, if required. 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>	FA	<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. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly checks and six monthly stock takes and accurate records.</p> <p>The facility uses an electronic medication system. Safe processes for medicine management were observed on the days of the audit. Interview with the GP verified that any change in a resident's medicine is automatically stored in a shared web portal, effectively connecting aged care facilities with pharmacies and the general practice.</p> <p>The staff observed demonstrated knowledge and understanding of their roles and responsibilities relating to each stage of medicine management. All staff who administer medicines have completed medication training and competencies.</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. There was one resident</p>

		<p>self-administering medicines on audit days.</p> <p>Medication errors are reported to the RN and recorded on an incident form. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service policies and procedures are appropriate to the service setting with a seasonal menu reviewed by a dietitian. 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, was sighted.</p> <p>In interview, the cook confirmed they were aware of the residents' individual dietary needs. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the cook.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided.</p> <p>The food temperatures are recorded, as are chiller and freezer temperatures. All decanted food is dated. Kitchen staff have completed food safety training.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. A cleaning schedule was sighted as was verification of compliance.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family/whānau 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</p>	FA	<p>An interview with the clinical manager verified residents, their family/whānau and their referrers would be notified, if entry to the facility would be declined. The clinical manager stated there had been no residents declined entry to the facility since their appointment to the position of the clinical manager. Resident's entry would be declined if the resident's assessment required a different level of care to the level provided at the facility or if the facility had full occupancy. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care</p>

family/whānau is managed by the organisation, where appropriate.		arrangements or residential services, confirmed at interviews.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	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 recorded. Over the next three weeks post resident's admission, the CM, CN or 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. The residents' interRAI assessments are up to date.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The residents' care plans are individualised, integrated and up to date. The care plan interventions reflect the risk assessments and the level of care required. Short term care plans are developed, when required and signed off by the RN when problems are resolved. In interviews, staff reported they receive adequate information for continuity of residents' care. The residents have input into their care planning and review. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interview.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes. Residents and family expressed satisfaction with the care provided. There were sufficient supplies of equipment seen to be available that comply with best practice guidelines and meet the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the	FA	A diversional therapist (DT) and an activities coordinator are employed to develop and implement the planned recreational programme. There is one activities programme that specifies activities for hospital residents, specific activities for rest home residents and activities that both the hospital and rest home residents can participate in. The DT assesses residents on admission to ascertain their activity and recreational needs with input from family, confirmed at interview. Activities assessments are analysed to develop the activities

service.		<p>programme that is meaningful to the residents. The residents' long term care plans reflect the activities assessment findings and are individualised and up to date. The planned monthly activities programme sighted matches the skills and interests evidenced in residents' assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Family/whānau and friends are welcome to attend all activities.</p> <p>A physiotherapist assesses residents for mobility needs; residents who have frequent falls and when a resident's condition deteriorates and mobility assessments require review. The physiotherapy assistant conducts the "get active programme" and assists the physiotherapist with residents' physiotherapy programmes.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the registered nurse or the charge nurse.</p> <p>Formal care plan evaluations, following reassessments occur every six months or as residents' needs change, however the evaluation to measure the degree of a resident's response in relation to desired outcomes and goals are not always recorded. Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p> <p>A short term care plan is initiated for short term concerns. 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/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 sends a referral to seek specialist service provider assistance. Referrals are followed up on a regular basis by the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and the hazard register is current. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Material</p>

<p>providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>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. Interviews with the household staff confirmed this.</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>	<p>FA</p>	<p>A current building warrant of fitness is displayed; with the date of expiry as 17 December 2017. There have been no building modifications since the last audit. There is evidence of areas being refurbished and painted in accordance with the maintenance plan. 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.</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>	<p>FA</p>	<p>There are adequate numbers of accessible toilets/bathing facilities. Visitor's toilets and residents toilets are located close to communal areas. All the toilets have a system that indicates if it is engaged or vacant.</p> <p>All the residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote resident's 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 ensuite. Staff were observed to supporting residents to access communal toilets and showers in ways that are respectful and dignified.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer</p>	<p>FA</p>	<p>There is adequate personal space in all the bedrooms to allow residents and staff to safely move around in the room. Equipment was sighted in rooms requiring this, with sufficient space for both the equipment and at least two staff and the resident, for example; hoists and wheel chairs. The resident's rooms are personalised with furnishings, photos and other personal belongings. Residents and families are encouraged to make the suite their own.</p>

group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has 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 enables residents to mobilise freely. The dining areas have ample space for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The laundry service was contracted out November 2015 to the laundry site at Atawhai Rest Home and Village, which is its own business entity and meets the regulatory requirements for a commercial laundry.</p> <p>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>	FA	<p>An evacuation plan is 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 and dining rooms. Call bell audits are routinely completed and residents and</p>

		<p>family state that there are prompt responses to call bells.</p> <p>External doors leading to the gardens and outside doors 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>	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) 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 position is assigned to a registered nurse. There is evidence of regular reports on infection related issues and these are communicated to staff and management. The IC programme is reviewed annually.</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 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, microbiologist and consultants in respect of infection control matters. The 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 the prevention and</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 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</p>

<p>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>facility</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The 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 with the education sessions' records 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>There is recorded evidence of the CM and the ICN attending the Hawke's Bay DHB IC information and support group meetings that include education sessions from clinical IC experts.</p>
<p>Standard 3.5: Surveillance 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 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.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the 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 interviews with clinical staff and management it was confirmed there had been an outbreak at the facility since last audit. Review of the outbreak documentation evidences: consultation with the HBDHB infection prevention and control advisor; a microbiologist; residents and family were provided with information about the outbreak; and treatment approval letters asking for individual approval to be treated as per guidelines. Correct IC measures were conducted. Sentinel events notification was completed. Outbreak register was maintained. The IC meeting in June 2016 was held for debriefing of the outbreak.</p>
<p>Standard 2.1.1: Restraint</p>	<p>FA</p>	<p>The definition of restraint and enabler is congruent with the definition in the standard. There were eight residents requesting the use of enablers and four residents using restraint on the days of the audit.</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>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 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>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 nationally due to use of low low beds and the use of perimeter mattress surrounds.</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 Oceania Care Company clinical and quality team 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 restraint coordinators. The restraint coordinator (RC) is the clinical manager (RN). The responsibilities for this role are defined in the RC position description.</p> <p>Restraints are 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 restraint is obtained from the GP, the 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>	FA	<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>	FA	<p>Protocols on safe use of restraint detail 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 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.</p> <p>Staff training and education in restraint use includes appropriate orientation and ongoing education.</p>

		<p>Evidence of ongoing education regarding restraint and challenging behaviours is evident. Restraint competency testing of staff is included in the education of staff. There is mandatory training for staff in restraint and this includes completion of the workbook.</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.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Evaluation of restraint occurs through restraint event reporting by the facility to the Oceania support office by measuring relevant clinical key performance indicators. Each individual episode of restraint is evaluated. The clinical files of residents using restraint evidence the restraint evaluation forms are completed and these include all the relevant factors in this standard.</p> <p>The restraint minimisation team meeting minutes evidence evaluation of each restraint use at the facility.</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 minute's evidence review of the compliance with the standard and includes: individual resident's restraint review; restraint register update; education review and any relevant restraint issues. Restraint use audits are conducted and include detailed review of residents' clinical files of residents who use restraint.</p> <p>Oceania national restraint authority group terms of reference are recorded. This group meet annually to review the compliance with the restraint standard and review of restraint use nationally. The last Oceania national restraint authority group meeting was conducted in February 2016.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	<p>Hospital files reviewed evidenced evaluations were completed, however the documentation of the degree of response/progress to meeting a desired outcome was not consistently recorded. Review of three hospital files of residents requiring evaluation was conducted (the hospital tracer and one other resident's file did not require evaluation as the admissions were within the last six months). Three additional hospital files were reviewed specifically in relation to evaluation of care indicating the degree of achievement to interventions and evidenced all six of six files did not have this recorded.</p>	<p>Care plans are not evaluated in a comprehensive manner.</p>	<p>Provide evidence care plans are evaluated in a comprehensive manner to indicate the degree of achievement to interventions provided.</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.