Oceania Care Company Limited - Elmwood Rest Home and Village

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:	Elmwood Rest Home and Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 August 2016 End date: 3 August 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: 135

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

Elmwood Rest Home and Village can provide rest home and hospital level care for up to 139 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with Counties Manukau District Health Board.

The audit process included the review of policies, procedures, supporting documents, resident files, staff files and observations, interviews with residents, family, management, staff and a medical officer.

The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager, two clinical leaders as well as a regional and executive management team. Service delivery is monitored. There are two areas requiring improvement relating to the long term care plan completion and evaluation of care plans.

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.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights information (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service information, is available. This information is given to residents' and their families on admission to the facility. The business and care manager is responsible for management of all complaints. Interviews confirmed that staff are polite and respectful of residents needs and communication is appropriate. The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related 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.

Oceania Care Company Limited is the governing body and is responsible for the service provided at Elmwood Rest Home and Village. The business and care manager is appropriately qualified and experienced. The clinical manager is responsible for oversight of clinical care.

Oceania Care Company Limited 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 and regional operations manager reports. Benchmarking reports include incidents/accidents, infections, complaints and clinical indicators with trends analysed to improve service delivery.

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

Residents' information is recorded accurately and in a timely manner. All residents' information is maintained in a secure environment, with no public access.

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 medium or high risk and/or unattained and of low risk.

Residents' files reviewed demonstrated the initial assessments and the initial care plans are conducted on admission to the facility. The long term care plans record resident's needs, goals and the assistance and interventions required. Where progress is different from expected, the service responds by initiating changes to the long term care plan or recording the changes on a short term care plan.

Activities are planned and the programme is available to residents and family. The activities programme includes a wide range of activities and involvement with wider community. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

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

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

been reviewed by a registered dietitian as meeting nutritional guidelines. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

All building and plant comply with legislation with a current building warrant of fitness in place expiring in March 2017. The environment is appropriate to the needs of the residents. The building and equipment complies with legislative requirements. A preventative and reactive maintenance programme includes equipment and electrical checks. The physical environment reduces risks and promotes safety and independence for residents. Residents are provided with accessible and safe external areas. Resident rooms are of an appropriate size to enable care. Essential emergency and security systems are in place, with regular fire drills completed. Call bells allow residents to access help, when needed, in a timely manner.

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.

The restraint minimisation and safe practice 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. The process of assessment, consent, care planning, monitoring and evaluation of restraint is recorded in policy and is implemented.

Staff education in restraint, de-escalation and challenging behaviour had 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 include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. The policies and procedures guide staff in all areas of infection control practice. New employees are provided with training in infection control practices and there is on-going infection control education available for all staff.

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	48	0	1	1	0	0
Criteria	0	99	0	1	1	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff have received education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) as a requirement of 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, encouraging independence. The information pack provided to residents on entry includes information on how to make a complaint and brochures on the Code advocacy services. Care staff are respectful towards residents and family members.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed	FA	The service has policies and systems in place to support residents and where appropriate their family who are being provided with information, to assist then to make informed choices and give informed consent. Care staff interviews confirmed staff training is provided to ensure policy and systems are adhered to. The business and care manager confirmed informed consent is discussed and documented at the time the resident is admitted to the facility and reviewed when required. Family interviews confirmed they have been made aware of and understand the principles of informed consent. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named

choices and give informed consent.		EPOAs (sighted in residents' files). The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files noted that all had appropriately signed advance directives. The general practitioner (GP) makes a clinical decision around resuscitation and ongoing treatment for residents who are not able to make an advance directive (and have no advance directive documented in the past). The advance directive is discussed with the family and/or EPOA prior to the doctor signing the form.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families on admission. 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 training on HDC Code of Health and Disability Services Consumers' Rights (the Code) Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they stated that they have been informed about advocacy services. The advocate for the area is invited and attends the residents' meetings.
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 and go out independently with their family and friends. The service has a visitors policy and guidelines to ensure resident safety and wellbeing is not compromised by visitors to the service. Evidence of residents' outings and appointments were reviewed in the resident's activity plan and care plan.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisation's complaints policy and procedures are in line with the Code and include timeframes for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. An extensive review of complaints was reviewed and every aspect of each complaint was reviewed and fully embedded in practice. communicated back to the complainant and all stakeholders implicated in the complaint. There was evidence of staff training on complaints in February 2016. Residents and Family members confirmed they knew the process and felt comfortable to complain.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment gains details of residnets' beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated. The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There were no documented incidents of abuse or neglect in the business status reports for 2015 or on incidents reviewed in resident files. Residents, staff, family and the general practitioner confirmed that there is no evidence of abuse or neglect. Abuse and neglect training is included in the mandatory training programme for staff, which was evidenced in the staff training records. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes residents' beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated. Staff were observed knocking before entering residents' rooms and closed doors while attending to residents' needs. Residents were observed being treated with respect by care staff during this audit and addressed residents using their preferred names. Activities and outings in the community are encouraged, and are part of the residents' activities plan. Values, beliefs and cultural aspects of care were recorded in residents' clinical files reviewed.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment gains details of residnets' beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated. The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There were no documented incidents of abuse or neglect in the business status reports for 2015 or on incidents reviewed in resident files. Residents, staff, family and the general practitioner confirmed that there is no evidence of abuse or neglect. Abuse and neglect training is included in the mandatory training programme for staff, which was evidenced in the staff training records. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes residents' beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated. Staff were observed knocking before entering residents' rooms and closed doors while attending to residents' needs. Residents were observed being treated with respect by care staff during this audit and

		addressed residents using their preferred names. Activities and outings in the community are encouraged, and are part of the residents' activities plan. Values, beliefs and cultural aspects of care were recorded in residents' clinical files reviewed.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The Māori health plan describes that the holistic view of Māori health is to be incorporated into the delivery of services. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. Access to Māori support and advocacy services is available if required from a local provider of health and social services. Staff members also provide cultural advice and support for staff if required. A cultural assessment is completed as part of the care plan for all residents. Specific cultural needs are identified in the residents' care plans and this was sighted in files reviewed. Staff are aware of the importance of whānau in the delivery of care for the Māori residents. Family/whānau are able to be involved in the care of their family members. Monthly culture themes are embedded in the activities programme.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents and family/whānau are consulted on their individual values and beliefs as part of the admission assessment process. Residents' files demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whānau contact details. During interviews care staff demonstrated their knowledge and understanding of the cultural safety in relation to care and confirmed that processes are in place for residents to have access to appropriate services. Documentation provided evidence that appropriate culturally safe practices are implemented and maintained, including respect for residents' cultural and spiritual values and beliefs. There is a culture of choice with the resident determining when cares occur, what clothes to wear, and choices in meals and activities.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The organisation has policies on discrimination, coercion, harassment, sexual, financial, or other exploitation, which include actions to be taken if there is inappropriate or unlawful conducts and is part of the mandatory staff training programme. Staff files reviewed included copies of the code of conduct that all staff are required to adhere to. Conflict of interest issues including the accepting of gifts and personal transactions with residents are included in the staff training, policies and procedures. Expected staff practice is outlined in job descriptions and employment contracts, which were reviewed on staff files. Residents and family interviewed reported that staff maintain appropriate professional behaviour.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The business and care manager (BCM) and the clinical manager (CM) two clinical leaders (CL) and registered nurses (RN) described the process for ensuring service provision is based on best practice, including access to education by specialist educators. Staff confirmed an understanding of professional boundaries and practice. 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 CM with input from the BCM and the regional clinical quality manager. Documentation reviewed provided evidence that policies and procedures are based on evidence-based rationales.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Accident/incidents, the complaints and the open disclosure policies alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These polices guide staff on the process to ensure open disclosure. Family are informed if the resident has an incident/accident, has a change in health, or a change in needs, as evidenced in residents' care plans and accident/incident documentation. There was documented evidence of communication with the general practitioner (GP) and other allied health professionals. The business and care manager advised access to interpreter services is available if required via the district health board. There is currently a multi-cultural mix of staff that are able to translate for all the residents who require a translator.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Elmwood Rest Home and Village is part of the Oceania Care Company Limited with the executive management team. The organisation's mission statement and philosophy are displayed at the entrance to the facility, information in booklets is given to new residents and staff training is provided annually. The business and care manager (BCM) provides monthly reports to the support office. The business status reports include quality and risk management issues, occupancy, current and ongoing human resource issues, quality improvements, internal audit outcomes and clinical indicators. The service has a BCM supported by a clinical manager (CM) and two clinical leaders (CL) and the clinical quality manager. The CM is a registered nurse with current practicing certificate and has been in the position for five weeks. The CM previously worked in aged care for eight years and is in the process of completing orientation specific to the role. The CM's position is full time. The BCM holds a current annual practising certificate and a bachelor's degree in management and administration, has been in aged care management role for eight years and has been in this role four years. The CM appointment was confirmed with the Ministry of Health.

Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the BCM, the CM assumes the role of the BCM, with support from the regional operations manager and the clinical quality manager.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Elmwood Rest Home and Village uses the Oceania Care Company Limited quality and risk management framework to guide practice. All policies are reviewed by support office with input from the clinical quality manager and BCM. Policies are current and in align with the Health and Disability Sector Standards, legislation and best practice guidelines. New and revised policies are presented to staff at staff meetings and are available in hard copies. The service has a documented control system to manage new and obsolete policies. The service has monthly staff/quality and residents' meetings. All meetings have a framework which is reflected in the meeting minutes, with timeframes and designated roles identified to implement any changes in practice and outcomes. The meeting minutes and communication with staff, family and residents reflect all aspects of quality improvements. A quality improvement plan with quality objectives was reviewed during the audit which guides the quality programme. Family/residents and staff satisfaction surveys are completed as part of their audit programme and results of the survey were reviewed. There was evidence of changes being implemented as a result of the survey. The service has a hazard register that identifies health and safety risks. There is a designated health and safety officer who oversees all aspects of health and safety and is supported by the BCM and health and safety committee, who meet monthly. A health and safety manual is available that includes relevant policies and procedures. There is a designated health and safety board in the staff room which is updated with new and relevant documentation. Service delivery is monitored through complaints, incidents/accidents and implementation of an internal audit programme, with corrective action plans and evidence of issues completed. All incidents go through the health and safety officer in consultation with the BCM, CM and the CLs.
Standard 1.2.4: Adverse	FA	The business and care manager (BCM) is aware of situations in which the service is required to report and

Event Reporting 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.		notify statutory authorities, including unexpected deaths, police attending the facility, sentinel events, infectious disease outbreaks and changes in key management roles. Staff interviews and review of documentation evidence that staff document adverse, unplanned or untoward events on an accident/incident form which are signed off by the business and care manager. Following analysis, corrective actions have been implemented and completed. Incidents had a corresponding note in the progress notes to inform staff of the incident. There have been no essential notifications to MoH and DHB since the last audit. There is currently only one coroner's enquiry dated 2014. The documentation regarding the investigation has been completed and the service is now waiting for the final coroner's report.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	The BCM, CM, CLs, registered nurses (RNs) and enrolled nurses (ENs) hold current practicing certificates along with health practitioners involved in the service. Staff files include appointment documentation for example signed contracts and job descriptions, reference checks, police checks and orientation sign off. There is an appraisal process in place with staff files indicating that all staff have completed an annual appraisal. The service is piloting a new electronic system which is a software system designed to capture the organisations mandatory education and training programme with annual competencies, annual appraisals, and annual practicing certificates. The system enables real time data to ensure staff are current in their competencies, Enrolled nurses job descriptions and interviews confirmed they are aware of and work within their scope of practice as an enrolled nurse. The service does not provide clinical oversight or care to the village residents. All staff complete an orientation programme, utilising a buddy system. The service has six registered nurses who completed InterRAI training with an additional two RN's booked to start their training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has staffing policies that guide the process. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy. The BCM uses a matrix system that identifies the number of hours required to the resident acuity ratio. On the day of the audit the numbers of hours for the past duty roster exceeded the number required. There are 136 staff, including the management team, clinical staff, a diversional therapist and activity staff, and household staff. There is a registered nurse on duty at all times. A registered nurse and clinical manager are on call 24/7.

		The service has 28 dual purpose beds. There are no dual purpose beds in the rest home section. All staff work across the rest home and hospital providing the skill mix needed to ensure appropriate services to all residents. Observation of residents and interviews with residents and family confirmed their needs are being met during service delivery. Rest home residents who are in the hospital area and mobile, attend activities in the rest home. Hospital residents who are not independent attend small groups of activities provided in the hospital, specifically planned for them or one-on-one activities with the activity staff, as appropriate for the individual resident. All residents are engaged in the activities programmes. Residents and families interviewed confirmed staffing is adequate to meet the residents' needs. Staff confirmed that they have sufficient time to complete cares scheduled.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family. There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information could be accessed in a timely manner. Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including designation. Resident files are protected from unauthorised access by being locked away in the nurses' station areas. Information containing sensitive resident information is not displayed in a way that it could be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder with medication. Staff confirmed that they read the long term plans at the beginning of each shift and are informed of any changes through the handover process.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has	FA	Entry and assessment processes are recorded and implemented. InterRAI assessments are completed for rest home and hospital level of care. The facility information pack is available for residents and their family, and contains all relevant information. The residents' admission agreements evidenced resident and/or family and facility representative sign off. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of

been identified.		resident care have been conducted.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is appropriate communication between families and other providers, that demonstrated transition, exit, discharge or transfer plans are communicated, when required. Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	Medication areas, including controlled drug storage areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug registers are maintained and evidenced weekly checks and six monthly physical stocktakes. The medication fridge temperatures are conducted and recorded. All staff authorised to administer medicines have current competencies. The medication rounds were observed and evidenced the 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. 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 GP. The residents who self-administer medicines do so according to policy.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service policies and procedures are appropriate to the service setting with a seasonal menu reviewed by a dietitian. In interview, the cook confirmed they were aware of the residents' individual dietary needs. The residents' dietary requirements are identified, documented and reviewed on a regular basis. 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. The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, their individual preferences were met and adequate food and fluids were provided.

		The food temperatures are recorded as are the fridge, chiller and freezer temperatures. All decanted food is dated. Kitchen staff have completed food safety training. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. Evidence of resident satisfaction with meals is verified by resident and family interviews, sighted satisfaction surveys and resident meeting minutes.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	There is a process for informing residents, their family and their referrers if entry is declined. The reason for declining entry is communicated to the referrer, resident and their family or advocate, in a timely manner and in a format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential service, confirmed at management interview.
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 assessment process includes paper based risk assessment tools and the interRAI assessment tool that are completed in the required timeframes. The facility has processes in place to seek information from a range of sources, for example: family; GP; specialist and referrer. The facility has appropriate resources and equipment, confirmed at staff interviews. Assessments are conducted in a safe and appropriate setting including visits from the GP. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote	FA	The residents' care plans were individualised, integrated and up to date. The care plan interventions reflected the risk assessments and the level of care required. Short term care plans were 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

continuity of service delivery.		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	The residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records are current. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated. There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met 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 service.	FA	In interview, the diversional therapist (DT) confirmed the activities programme meets the needs of the service group and the service has appropriate equipment. The activities staff plan, implement and evaluate the activities programmes. There is one activities programme for the rest home and hospital residents. On audit days, it was observed that the activities programme provided was attended by both rest home and hospital residents. Interviews with residents and family confirmed satisfaction with the variety of activities. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. There are current, individualised activities care plans in residents' files. The residents' activities attendance records are maintained. The residents' meeting minutes evidenced residents' involvement and consultation of the planned activities programme. For residents who are unable to attend group activities, one on one activities are provided with residents' consent.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes, however long term care plans evaluations did not consistently record the evaluations in a comprehensive manner. Timeframes in relation to care planning evaluations are documented. The residents' care plans are up-to-date and reviewed at least six monthly. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews. The residents' progress records are entered on each shift. When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans are in some of the residents' files, used when required. Interviews with family confirmed, the family are notified of any changes in the

		resident's condition. There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Appropriate processes are in place to provide choices for residents in accessing or referring to other health and/or disability services. Family communication sheets confirmed family involvement. An effective multidisciplinary team approach is maintained and progress notes detailed relevant processes are implemented. 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.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place and incidents were reported on in a timely manner. 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. The hazard register is current. Staff received training and education to ensure safe and appropriate handling of waste and hazardous substances. There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example, goggles/visors, gloves, aprons, footwear and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas. Staff interviews and training records confirm knowledge and implementation of management of waste and hazardous substances.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their	FA	A current building of warrant of fitness is displayed, expiry 16 March 2017. There have been no building modifications since the last audit. There is a planned maintenance schedule implemented. Equipment is available, including shower chairs and sensor alarm mats. There is an annual test and tag programme and this is current with checking and calibration of clinical equipment completed annually. Interviews with staff and observation of the facility

purpose.		confirmed there is adequate equipment. There are quiet areas throughout the facility for residents and visitors to meet. There are internal courtyards and lawn areas with shade, seating and outdoor tables.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are adequate numbers of accessible toilets/bathing facilities. Visitors 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. Residents and family members reported that there are sufficient toilets and showers. Auditors observed residents being supported to access communal toilets and showers, in ways that are respectful and dignified.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Equipment was sighted in rooms requiring this with sufficient space for the equipment, staff and the resident. Rooms can be personalised with furnishings, photos and other personal adornments and the service encouraged residents to make the suite their own. There are designated rooms to store mobility aids, such as hoists and wheel chairs. There is adequate space in the bedroom for walking frames for residents to be able to access safely during the day and night, if required. The hospital rooms and assisted care rooms are larger to accommodate specific aids.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation,	FA	The service has lounges, dining rooms and an activities room. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents are able to access areas for privacy when required. The dining areas have ample space for residents.

activity, and dining needs.		
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is completed on site, with covered laundry trolleys and bags in use for transport. 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 stated that the laundry is well managed. There are cleaners on site during the day, seven days a week. The cleaners have a trolley to put chemicals in and they are aware that the trolley must be with them at all times. All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. The cleaner interviewed confirmed that they have training at least annually. Cleaning and laundry is monitored through the internal audit process with no issues identified in audits.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The service has an approved fire evacuation plan. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. Staff attend six monthly fire drills. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. There is always at least one staff member with a current first aid certificate on duty. All required fire equipment was 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 barbecues. An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas, including the hallways and dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells. Call bell response times checked by the auditors on the day of the audit, confirmed prompt response. The doors are locked in the evenings. Staff complete a check in the evening that confirms security measures have been put in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an	FA	There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All heating is provided with radiators that run from the boiler on site. There are designated external areas for

environment that is maintained at a safe and comfortable temperature.		residents to smoke. Families interviewed confirmed the facility is maintained at an appropriate temperature.
Standard 3.1: Infection control management 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.	FA	The infection control policies and procedures provide information and resources to inform staff on infection prevention and control. The responsibility for infection control is defined in the infection control policy. There is a signed infection control nurse's (ICN) job description outlining responsibilities of the position. The ICN is supported in their role by the business and care manager (BCM) and the clinical team. There is evidence of regular reports on infection related issues and these are communicated to staff and management. The Oceania wide infection control programme is reviewed annually by the Oceania infection control committee (company-wide). The facility's infection control programme is reviewed by the infection control team at the facility.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICN takes the leadership role in the infection control team. The ICN has access to relevant and current information, which is appropriate to the size and complexity of the service. The implementation of the infection control programme is monitored via internal audits, and benchmarking.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies	FA	The Oceania infection control committee (company-wide) develop and review the infection control policies and procedures to be implemented within the Oceania facilities. They are developed and reviewed regularly in consultation and input from relevant staff, and external infection control specialists. The policies and procedures are up to date, reflect current accepted good practice and relevant legislative requirements. The infection control manual is readily accessible to all personnel, confirmed at staff interviews.

and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	New staff receive orientation to infection control upon commencement of employment. The infection control education is provided to all staff, as part of the on-going in-service education programme. The staff in-service education is provided by the ICN. There is evidence this has occurred during 2016. Education sessions have evidence of staff attendance/participation and content of the presentations. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews. The ICN has undertaken infection control education/training relevant to the role. In interviews, staff advised that clinical staff identify situations where infection control education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted.
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.	FA	The infection control surveillance policy identifies the requirements around the surveillance of infections. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short term care plans in place. Monthly surveillance analysis is completed and reported at meetings and entered in the clinical indicators on the Oceania intranet. This information is reviewed by the Oceania clinical quality team and reported to the Oceania board on a monthly basis. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the clinical leaders, the clinical manager, 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. In interview, the ICN confirmed no outbreak has occurred at the facility since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively	FA	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 in policy. There were no residents requesting the use of enablers and two residents using restraint on the days of the audit. The restraint use is documented in residents' care plans. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist

minimised.		them to maintain independence and/or safety, confirmed at staff and management interviews and documented in policy. 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.
Standard 2.2.1: Restraint approval and processes 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.	FA	The Oceania Care Company Limited 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 at the facility is the clinical leader (CL). The responsibilities for this role are defined in the position description. 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 evidenced consent for restraint is obtained from the GP, restraint coordinator and the resident and/or a family member.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessment is completed prior to commencement of any restraint. The clinical files of residents using restraint evidenced the restraint assessment authorisation and plans were in place. Restraint assessments evidence all appropriate factors have been taken into consideration.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	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. Staff education in restraint use is conducted at orientation and through the ongoing education sessions. Evidence of ongoing education regarding restraint and challenging behaviours was sighted. Restraint

		competency testing of staff is included in the education of staff. The restraint register is up to date and records all necessary information to provide an auditable trail of restraint events. Health care assistants are responsible for monitoring and completing restraint forms when the restraint is in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Evaluation of restraint occurs through restraint event reporting by the facility to the Oceania support office measuring relevant clinical key performance indicators. Each individual episode of restraint is evaluated. The clinical files of residents using restraint evidenced the restraint evaluation forms were completed and included all relevant factors in this standard. The resident (if able) and the family are involved in the evaluation of the restraints' effectiveness and continuity at the multidisciplinary meetings. The restraint minimisation team meeting minutes evidence evaluation of each restraint use at the facility.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	There is evidence of monitoring and quality review of the use of restraint at the facility. The restraint minimisation team meeting minutes evidenced review of the compliance with the standard. Oceania national restraint authority group meet annually to review the compliance with the restraint standard and review of restraint use nationally. National restraint benchmarking and analysis results indicated there has been reduction in restraint use nationally due to use of low/low beds and the use of perimeter mattress surrounds.

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)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Residents' initial care plans are completed on admission. Assessments are completed and recorded on the residents' long term care plans. Long term care plans record all the residents' needs, goals, required assistance and interventions. There was evidence that four of the 12 long term care plans were not completed within the three week timeframe post admission to the facility.	The long term care plans are not consistently completed within the required timeframes.	Provide evidence the long term care plans are completed within the required timeframes. 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support	PA Low	The residents' files reviewed evidenced evaluations are completed, however the documentation of the degree of response/progress to meeting a desired outcome was not consistently recorded. Review of five residents' files of residents requiring care plan evaluation was conducted (seven resident's files did not require evaluation as the admissions of those residents were within last six months). Four additional residents' files were reviewed specifically in relation to evaluation of care indicating the degree	Residents' long term care plan evaluations do not consistently record the evaluations	Provide evidence the evaluations of long term care plans are recorded in a comprehensive manner to

and/or intervention, and progress towards meeting the desired outcome.		of achievement to interventions and evidenced eight of the nine files did not have this recorded.	were conducted in a comprehensive manner.	indicate the degree of achievement to interventions provided. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, these 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.