Oceania Care Company Limited - Whareama Rest Home & 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:	Whareama Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 June 2017 End date: 8 June 2017

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: 71

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

Whareama Rest Home (Oceania Healthcare Limited) can provide care for up to 76 residents, including rest home and hospital care. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. Occupancy on the first day of the audit was 71.

The audit process included the review of policies, procedures, resident and staff files, and observations and interviews with residents, family, management, staff and the general practitioner.

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

A rating of continuous improvement has been given relating to the management of quality improvement data.

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.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible in information packs and displayed within the service. Residents and family members confirmed their rights are met, staff are respectful of their needs and communication is appropriate.

Residents, families and enduring power of attorney are provided with information required prior to giving informed consent. Time is provided if any discussions and explanation are required relating to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

A complaints register is maintained. Complaints are managed as per timeframes in the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights.

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 Healthcare Limited is the governing body and is responsible for the service provided at Whareama Rest Home. The business and care manager is qualified and experienced in management systems and processes. The business and care manager and clinical manager are new to their roles and are supported by the clinical and quality manager (regional), the operations manager (regional) and the senior clinical and quality manager (national) regarding oversight of the service and clinical care.

Quality improvement is monitored and bench marking reports include incident/accidents, infections, complaints and clinical indicators. Trends are 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 residents’ 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.

Resident information is current, identifiable, accurately recorded and stored securely. Clinical notes are accessible to all clinical staff.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

The Needs Assessment Coordination Service ensures safe and appropriate access to the service. Residents' needs are assessed on admission by a registered nurse using the initial nursing risk assessments and the data collected is used to create initial care plans. Nursing care plan evaluations are documented and resident focused.

Person centred care plans are based on the outcome of the interRAI assessments and indicate progress towards meeting the residents' desired outcomes. Where the progress of a resident is different from expected, a short-term care plan is completed recording short-term problems. The residents and/or their families contribute to care planning and evaluation of care.

Planned activities are managed by a diversional therapist and activities coordinator. Activities are appropriate to the group setting. Resident and family interviews confirmed satisfaction with the activities programme. Activities are provided either within group settings or on a one-on-one basis.

There is a medicine management system in place. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. There were two residents self-administering medicines. Residents who self-administer medicines had competency checks completed by the general practitioner. Staff maintained records when the residents administered medicines and residents were provided with safe and appropriate storage of their medicines.

The menus meet national nutritional guidelines for older people and have been reviewed by the organisations' registered dietitian. Residents' special dietary requirements and needs for assistance during feeding are met. 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. The environment is appropriate to the needs of the residents. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents are provided with accessible and safe external areas. Residents' rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Essential emergency and security systems are in place and fire drills completed every six months. Call bells are available to all residents and are monitored monthly.

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 service uses Oceania Healthcare Limited policies and procedures for restraint minimisation and safe practice. The policies are aligned with the requirements of the standard. The service has systems in place to ensure the management of restraint, should they need to implement restraint or make use of enablers.

Staff complete annual education and training on restraint and enabler management processes. At the time of the on-site visit, there were six restraints and one enabler being used by residents.

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.

Infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection according to the requirements of the standard. Induction and orientation of new staff include training in infection control practices. The service has ongoing infection control education and training available for all staff.

The surveillance programme is appropriate for the size and complexity of the services provided. Surveillance of infections is occurring according to the descriptions of the processes in the infection control programme. Infection prevention and control data is collected, collated, analysed and reported through all levels of the organisation, including governance.

Infection control surveillance data is benchmarked internally against other Oceania Healthcare Limited facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. Residents stated they receive services that meet their needs and they receive information relative to their needs. All staff have had training in the Code during the previous 12 months and staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice including: maintaining residents' privacy; giving residents choices; encouraging independence and ensuring residents can continue to practice their own personal values and beliefs. The auditors noted respectful attitudes towards residents on the days of the audit.
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 choices and	FA	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 CM and BCM reported informed consent is discussed and recorded at the time the resident is admitted to the facility. Residents and family confirmed they have been made aware of and understand the

give informed consent.		principles of informed consent. Residents/family are provided with various consent forms on admission for completion as appropriate and these were reviewed on residents' files. Copies of legal documents such as EPOA for residents are retained at the facility. Where residents have named EPOAs and these were reviewed on residents' 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	Resident information relating to advocacy services is available at the entrance to the facility and in information packs provided to residents and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Staff training regarding advocacy services was last provided in 2017. The health and disability advocate visits the service, as confirmed by the management team. Family and residents confirmed the service provides opportunities for the family/EPOA to be involved in decisions and they stated they have been informed about advocacy services. Family members confirmed they act as advocates for their family member and also for other residents if they identify any needs.
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 facility has policies regarding advocacy/support services in place. Family confirmed that advocacy support is available to them and information packs include 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. Resident and family interviews confirmed they have access to external services such as the Returned and Services' Association (RSA), church groups and the Citizens Advice Bureau. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Staff have been trained in the role of advocacy services.
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 is in line with the Code and include periods 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 is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved. 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 can raise concerns or issues. Meeting minutes confirmed the process.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The business and care manager (BCM) and the clinical manager (CM) discuss the Code with residents and their family on admission. Discussion relating to the Code is also included on the agenda and discussed at the residents' meetings. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. Residents and families confirmed their rights are being upheld by the service. The posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English.
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	Whareama Rest Home has a philosophy that promotes dignity, respect and quality of life. The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings. Healthcare assistants reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families confirmed that residents' privacy is respected. A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident. 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 are no documented incidents of abuse or neglect in the business status reports or on the incidents reviewed in residents' files. Residents, staff, family and the general practitioner confirmed that there was no evidence of abuse or neglect. Staff interviewed were aware of the need to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues. Resident files reviewed confirmed that cultural and/or spiritual values and individual preferences are identified.

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 organisation has a cultural responsiveness policy which outlines the processes for working with people from other cultures. A Māori health plan outlines how to work with Māori and the relevance of the Treaty of Waitangi. 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. Staff who identify as Māori can provide support for Māori residents and their families, if needed. Specific cultural needs are identified in the residents' care plans.
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	Documentation provided evidenced 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. Staff and residents confirmed there are choices for residents regarding their care and services. Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the residents' cultural values and beliefs. The initial care plan, the long-term care plan and interRAI assessment are based on this information.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility implements the Oceania Healthcare Limited (Oceania) policies and procedures based on good practice, current legislation and guidelines. Interviews confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. Staff training includes discussion of the staff code of conduct and prevention of inappropriate care. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination. Staff complete orientation and induction include recognition of discrimination, abuse and neglect. Staff confirmed their understanding of professional boundaries. Staff files reviewed included copies of code of conduct policies and 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.
Standard 1.1.8: Good Practice Consumers receive services of an	FA	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.

appropriate standard.		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. 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	Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and families. There is evidence of communication with the general practitioner (GP) and family following adverse events. Family are informed if the resident has an incident/accident, has a change in health or a change in needs. Family contact is recorded in residents' files. Families confirmed that they are invited to the care planning meetings for their family member and can attend the residents' meetings. Families confirmed they are well informed. Residents confirmed that they are aware of the staff that are responsible for their care and staff communicate effectively with them. Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney (EPOA) of any accident/incident that occurs. 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 or a volunteer from the community. Staff are familiar with how translating and interpreting services can be accessed. Residents in the service did not require interpreter services on audit days. Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. The admission agreements reviewed were signed on the day of admission.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate	FA	Whareama Rest Home is part of the Oceania Healthcare Limited (Oceania) with the executive management team providing support to the service. The Oceania vision, values, mission statement and philosophy are displayed at the entrance to the facility, included in information booklets and in staff training provided annually.

to the needs of consumers.		The service has a business and care manager (BCM), supported by a clinical manager (CM) and regional clinical quality manager (CQM). The BCM has been in the role at Whareama Rest Home for six weeks. Previously the BCM worked in the same role but another facility within the Oceania Group for three years and prior to that worked as a roving BCM for Oceania. The CM has also been in the position for six weeks, however, was previously a CM in another Oceania facility. Both the BCM and CM have current annual practising certificates. The management team is well supported in their roles and have completed appropriate induction and orientation to their roles. Communication between the service and managers occur monthly, with the regional CQM providing support during the audit. The monthly business status report provides the executive management with progress against identified indicators. The facility can provide care for up to 76 residents. On the first day of audit there were 71 residents living at the facility including 45 residents requiring rest home level of care and 26 residents requiring hospital level of care.
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	During a temporary absence of the BCM, the CM is responsible for the day to day operation of the service and is supported by the regional CQM and the regional operations manager. In the absence of the CM, the BCM with the support and help of the regional CQM, ensures continuity of clinical services.
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	The facility uses the Oceania quality and risk management framework to guide practice. Oceania support office reviews all policies with input from business and care managers and the national clinical and quality team. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines, including policy on the interRAI assessment process. All policies are subject to reviews as required with all policies current. The service implements organisational policies and procedures to support service delivery. Policies are available to staff in hardcopy. New and revised policies are presented to staff to read and staff sign to evidence that they have read and understood the new/revised policy. Service delivery is monitored through review of incidents and accidents; complaints management; surveillance of infections; pressure injuries; soft tissue/wounds; and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues completed. Internal audits are completed in line with the quality audit schedule, with evidence of corrective actions identified and implemented.

		Monthly staff/quality meeting minutes, including quality improvement, health and safety, and infection control, evidence communication with all staff around all aspects of quality improvement and risk management. There are bi-monthly resident meetings coordinated by the diversional therapist that keep residents informed of any changes. Staff reported they are kept informed of quality improvements. Families are invited to attend the resident meetings. The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly, with a facility health check completed quarterly by the regional CQM. The satisfaction survey for family and residents was completed in 2017 and reflects the satisfaction of the residents and family. The service achieved a recommendation for continuous improvement on the basis that management processes are implemented and modified to achieve beyond the expected full attainment.
Standard 1.2.4: Adverse 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.	FA	The BCM is aware of situations in which the service is required to report and 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 evidenced staff document adverse, unplanned or untoward events on an accident/incident form which are signed off by the BCM. There have been no deaths referred to the coroner and no essential notifications to district health board since the last audit. The Ministry of Health were informed of the new facility appointments.
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 and registered nurses (RN) hold current annual practicing certificates. There was evidence in the staff files the contracted GP and contracted allied health professionals, including the physiotherapist had current annual practicing certificates. Staff have current annual performance appraisals on file. Registered nurses are aware of their scope of practice and work within the guidelines of their scope. 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 called GEM, for clinical and non-clinical staff, which covers all the mandatory requirements. 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. All staff complete an orientation programme and healthcare assistants (HCA) are paired with a senior HCA for several shifts or until they demonstrate competency in a number of tasks, including personal cares. Healthcare assistants confirmed their roles in supporting and buddying new staff.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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. There are 73 staff, including the management team, clinical staff, diversional therapist, activities coordinator, physiotherapist, and housekeeping staff. Rosters were reviewed and there is sufficient cover to provide safe services. Registered nurse cover is provided 24 hours a day and there are at least three HCA on at night. There are two charge nurses who report to the CM, and support the RNs seven days per week, including after-hour on-call duties. Healthcare assistants and families interviewed reported there are adequate staff available. Resident and family interviews confirmed that services meet their needs. Staff confirmed that workloads are at an appropriate level. There is an ongoing recruitment programme in place.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retained relevant and appropriate information to identify and track residents' records. This includes involvement of family. There are sufficient details in residents' files to identify resident's ongoing care, history, and activities. Entries are legible, dated and signed by the relevant HCA, RN or other staff member, including designation. Approved abbreviations are listed. Residents' information is stored securely in staff areas. Clinical notes are current and accessible to all clinical staff. Information containing sensitive resident information is not displayed in a way that it could be viewed by other resident's medical care or members of the public. Individual resident files demonstrate service integration. The resident's national health index number, name, date of birth and GP are used as the unique identifiers. Clinical staff interviewed

		confirmed they know how to maintain confidentiality of resident information.
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 been identified.	FA	Entry processes into the service are recorded and implemented. Needs assessments are completed for rest home and hospital level of care. All resident files reviewed had current needs assessments completed. The philosophy of the service is displayed in a prominent area in the foyer and communicated to residents, family and staff. The information pack is available for residents and their family and contains relevant information on services at the facility, and within the organisation. The residents' admission agreements evidenced resident and/or family sign-off. The admission agreement defines the scope of the service and includes contractual requirements. Interviews with residents and family and review of records confirmed the admission process was completed by staff in timely manner. Relevant admission information is communicated to residents and their families.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Resident exit, discharge or transfer is managed in a planned and coordinated manner. There is open communication between services, the resident and the family. At the time of transition, appropriate information is supplied to the service or individual responsible for the ongoing management of the resident. Referrals are documented in the residents' 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	The medication areas evidence appropriate and secure medicine dispensing systems, free from heat, moisture and light. Medicines are stored in original dispensed packs. The drug registers are consistently maintained with registered nurses completing weekly checks. Six monthly physical stocktakes are undertaken by the pharmacy. The medication fridge temperatures are conducted and recorded. Staff authorised to administer medicines have current competencies. Administration records and specimen signatures are maintained. Staff education in medicine management is provided. Electronic medicine charts evidenced current 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' medicine charts record all residents' medication. The service's policies provide guidelines and processes for residents to self-administer medicines.

		At the time of the audit there were two residents who self-administered medicine at the facility. Both residents complete competency testing, keep record of administered medicines and store their medicines securely.
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	Registered nurses complete dietary assessments on admission. Each resident has a dietary profile developed. Personal food preferences of the residents, special diets and modified nutritional requirements are known to the kitchen manager and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, was sighted. Residents' files demonstrated monthly monitoring of individual resident's weight and where there is evidence of weight-loss, residents' weight is monitored weekly. Residents who are identified with weight loss have completed short-term care plans with relevant interventions to monitor and manage their weight. Interviews with residents stated their satisfaction with the food service. Residents' individual preferences are met and adequate food and fluids is provided. Resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Fridge temperatures are monitored three times per day and food temperatures are monitored twice a day. The kitchen staff have all attended food safety training. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.
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	The service has a process in place to inform residents and family of the reasons why services had been declined, should this occur. Referral agencies are informed of the reasons for decline of entry. Resident and/or their family is referred to more appropriate services in the area, when access to the service is declined. Decline of entry only occurs if the residents' needs are not within the scope of the service or if a bed was not available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The residents' needs, outcomes and goals are identified through the assessment process and recorded in their personal file. The service has processes in place to seek information from a range of sources, for example, the resident; family; GP; specialist and the referrer. Policies and protocols are in place to ensure continuity of service delivery. The residents' files evidenced discharge and/or transfer information from the district health board

		where required. The service has appropriate resources and equipment. The assessments are conducted in a safe and appropriate environment, usually the resident's room, including visits from the GP. Interviews with residents and families confirmed their involvement in the assessments, care planning, review, treatment and evaluations of care.
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. Recorded interventions reflect the risk assessments and the level of care required. InterRAI assessments are completed by RNs and are used to inform the person centred care plans. Short-term care plans are developed for the management of acute problems, when required, and signed off by the RN when problems are resolved. Interviews with residents and family members confirmed they have input into the care planning and review processes.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents' care plans evidence detailed interventions based on assessed needs, desired outcomes and goals of residents. The GP documentation and records are current. Interviews with residents and families confirmed current care and treatments meet residents' needs. The service maintains family communication records in resident files. Nursing progress notes and observation charts are maintained by staff. Staff confirmed they are familiar with the needs of the residents who were allocated to their care.
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	Interviews with the diversional therapist (DT) and activities coordinator (AC) confirmed the activities programmes meet the needs of the residents. The DT and the AC plan, record, implement and evaluate the activities programmes. The service has one activities programme for the rest home and hospital. Regular exercises and outings are provided for those residents able to participate. The activity programmes 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. Residents' meeting minutes evidenced residents' involvement and consultation of the planned activities programme.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and recorded in the progress notes. Changes are noted and reported to the RN or CM. The degree of a resident's response in relation to desired outcomes following reassessment which occur every six months. Where progress is different from expected, the service develops a short-term care plan for the management of short-term concerns/acute problems, for example: infections, wounds, weight loss and falls. Short-term care plans are reviewed daily, weekly or fortnightly, as indicated by the degree of risk noted during the assessment process. Wound care plans evidenced timely reviews. Interviews verified residents and family are included and informed of changes.
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	The service has processes in place to provide choices to residents when accessing or when being referred to other health and/or disability services. The family communication sheets, located in the residents' files, confirmed family involvement. The service provides choices to residents through a multidisciplinary team approach and progress notes record facilitation of choices to the residents.
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 the hazard register is current. Policies and procedures specify labelling requirements in line with legislation, including the requirements 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 with the household staff confirmed this. 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 required.
Standard 1.4.2: Facility Specifications Consumers are provided with an	FA	A current building warrant of fitness is displayed. There have been no building modifications since the last audit. There is evidence of areas being refurbished and painted in accordance with the

appropriate, accessible physical environment and facilities that are fit for their purpose.		maintenance plan. The service has a planned maintenance schedule implemented with an annual test and tag programme. This is up to date with checking and calibrating of clinical equipment annually. Interviews with staff and observation of the facility confirmed there is adequate equipment including; pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There are quiet areas throughout the facility for residents and visitors to meet, providing privacy, when required. There are 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' toilets and residents' toilets are located close to communal areas. All the toilets have a system that indicates if it is engaged or vacant. All the residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residents' independence. Residents and family members reported there are sufficient toilets and showers with some rooms in the rest home/hospital area having shared ensuites. Staff were observed supporting residents 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. Equipment was sighted in rooms requiring this with sufficient space for the equipment, staff and the resident. Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own. There are designated areas to store mobility aids, hoists and wheelchairs. The rooms are large enough 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, activity, and dining needs.	FA	The service has lounge/dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The dining areas have ample space for residents. Residents can choose to have their meals in their rooms.

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 off site and is delivered daily. Laundry is transported in appropriate colour coordinated linen bags. Laundry staff sort the personal laundry in the evening and healthcare assistants are required to return linen to the rooms. Residents and family members confirmed that the laundry is well managed. There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and are aware that the trolley must be with them at all times. Cleaners were observed, keeping the trolley in sight and limiting the chemical cleaning agents on the trolley. All chemicals are in appropriately labelled containers. Training about the use of products has been provided throughout the year. Cleaning 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	An evacuation plan has been approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. A fire drill is conducted six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. Fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes. There is always one registered nurse with a current first aid certificate on duty. A disaster management plan is in place with clear information for staff to follow in the event of an emergency. There are adequate supplies, including food, water, blankets, emergency lighting and gas barbeque. An electronic call bell system is in place. 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. Observation on the days of audit and interviews with residents and families confirmed there are prompt responses to call bells. Sensor mats are used where appropriate.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable	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. Families and residents confirmed that rooms are maintained at an appropriate temperature.

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 prevention and control (IPC) policies and procedures manual provides information and resources to inform staff on IPC processes. Strategies are in place to prevent exposure of infections to residents, visitors and staff. The responsibility for infection control is clearly defined in the IPC policy that includes the responsibilities of the organisations' national infection control committee; the infection control nurse (ICN) and the infection control team. There is a signed ICN job description outlining responsibilities for this role. The ICN is the clinical manager who is supported in the role by the charge nurses, business and care manager, the regional clinical and quality manager and the infection control team.
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 has access to relevant and current information, appropriate to the size and complexity of this service. Infection control is an agenda item at the facility's meetings. The internal audit programme includes infection control audits to monitor the implementation of the IPC programme.
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 and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The Oceania infection control committee develop and review the IPC policies and procedures to be implemented within its facilities. Policies are developed and reviewed regularly in consultation and with input from relevant staff and external specialists. The infection control manual is up to date, policies reflect current accepted good practice and reflects relevant legislative requirements. The infection control manual is easily accessible to staff.
Standard 3.4: Education The organisation provides relevant education on infection control to all	FA	Infection control education is provided to all staff, as part of their orientation and as part of the ongoing in-service education and training programme. The ICN has attended external education relating to IPC. Education sessions have evidence of staff attendance and participation. The

service providers, support staff, and consumers.		content of presentations is available for review. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews. The infection control staff education and training is provided by the ICN. The service includes annual infection control training for residents as part of a resident meetings. Staff confirmed that one on one infection control education of residents occurs in an informal manner.
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 ICN is responsible for the surveillance programme. Infection control surveillance occurs monthly with analysis of data and reported at staff and quality meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infections. Staff complete infection logs for all episodes of infections. Residents diagnosed with infections had a short-term care plan in place for the management of the infection. Interviews with staff reported they are made aware of infections through short-term care plans, progress notes, handover and verbal feedback from RNs, charge nurses (CN) and the CM. There have been no outbreaks since the previous audit. The facility's surveillance data is benchmarked against other Oceania facilities and this information is shared with staff and management.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The Oceania wide policy 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 procedures. There were six residents at the facility using restraints and one resident using an enabler during the on-site audit. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. Interviews with staff and staff records confirmed that restraint minimisation and safe practice, enabler usage and de-escalation education and training is provided. Oceania support office maintain records of restraint use and analysis is conducted monthly by the business and care and clinical and quality managers. National results indicated there has been a reduction in restraint used for the organisation due to the use of low beds and perimeter mattresses.
Standard 2.2.1: Restraint approval	FA	The national clinical and quality team are responsible for approving any form or type of restraint

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.		practice used throughout Oceania facilities. Oversight of restraint use at individual Oceania facility is the responsibility of restraint coordinators. The restraint coordinator at Whareama Rest Home is the clinical manager (CM). The responsibilities for this role are defined in the position description, sighted. The restraint coordinator has completed training in restraint minimisation and restraint management relevant to their role and was able communicate their knowledge relating to the restraint minimisation standard. Restraints are authorised following an 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 a 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	The restraint assessment is completed prior to commencement of any restraint. The clinical files of residents using restraint evidenced the restraint assessment authorisation and care plans are in place. Assessment includes identification of restraint risks and monitoring timeframes. Restraint assessments evidenced the restraint coordinator's sign off and other appropriate factors (as listed in criterion 2.2.2.1) 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. Protocols 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 and sensor mats. The policies that guide staff in the safe use of restraint include approved forms of restraint; restraint indications; associated risks; safety precautions; authorisation; reporting and monitoring requirements. Induction and orientation, as well as training and education, include restraint processes. Evidence of ongoing education regarding restraint and challenging behaviours was evident. Restraint competency testing of staff is included in their education process. Staff monitoring restraint are overseen by registered nurses and charge nurses. The restraint register is up to date and records necessary information to provide an auditable trail of restraints. Healthcare assistants are responsible for monitoring and recording restraint monitoring processes when restraints are in use.

Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Evaluation of restraint occurs through 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 are completed. The restraint minimisation team meeting minutes evidenced evaluation of each restraint used in the facility. Residents and the family are involved in the evaluation of the effectiveness and needs for continuing restraint. Progress notes verified restraint related records.
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 restraint use at the facility. The restraint minimisation meeting minutes evidenced review of the compliance with the standard. Restraint meetings are held monthly. Audits relating to restraint use are conducted and include detailed review of residents' clinical records. The 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.

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.

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	A facility’s health check audit completed by the regional CQM, identified 22 requirements for improvement in a wide variety of areas, including staff training; human resource; incident reporting; corrective actions; meeting minutes; registers, and environmental issues. This provided a baseline for an improvement process. The BCM, with support of the quality team, implemented corrective actions and continued to analyse and report outcomes at several different forums, for example staff and quality meetings, key performance indicators in reports to the support office and information provided in management reports. After implementation of corrective actions, the BCM implemented additional systems and processes to	The requirements for improvement identified in the facility’s health check audit were addressed. The review process included analysis and reporting the evidence at a variety of forums. During the on-site audit, documentation reviews confirmed rigorous systems and processes improving service provision. The outcome of the certification audit verified successful implementation of change. Achievement beyond the expected full attainment was evident in management creating systems and processes to ensure early identification of possible issues and create continuity in the management of these.

		prevent reoccurrence of incidents. No further corrective actions have been required due to managements' implementation of this change process. Consumer safety and continuity of care was measured in respect of these previous findings, with positive outcomes reported. Measurements of consumer safety demonstrated an improvement as a result of the quality improvement initiative.	

End of the report.