

# Oceania Care Company Limited - Elmwood Rest Home and Village

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## Introduction

This report records the results of a Partial Provisional Audit; Surveillance 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: 31 January 2018      End date: 1 February 2018

**Proposed changes to current services (if any):** The conversion of 21 serviced apartments to dual purpose services and to retrofit sluice room and nurses station in this wing. This increases the total of dual services beds from 30 to 51. Total beds will be 160.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 121



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Elmwood Rest Home and Village is part of Oceania Healthcare Limited. A surveillance audit was undertaken to measure compliance with a subset of the Health and Disability Services Standards and the contractual agreement with the district health board. At the time of the audit, the facility had 121 residents with a capacity for up to 139 residents.

This partial provisional audit was undertaken to establish the level of preparedness for 21 serviced apartments/independent living units to become dual purpose services and to retrofit a sluice room and nurses station. This will increase the total of dual services beds from 30 to 51 and the total number of beds will increase to 160.

The audit process included the review of policies, procedures, staff and resident files, and interviews with staff, residents, their families and a tour of the facility. The business and care manager is responsible for the overall management of the facility with the support of the clinical manager and regional clinical and quality manager. National support from the Oceania operations manager is also available.

The previous requirements for improvement relating to completing long-term care plans within the required timeframes and comprehensiveness of evaluations remain open. There are new areas identified as requiring improvement relating to quality and risk management (policy review, adverse events), interRAI and falls assessments, updating care plans when changes in health occur, medicines management and environmental safety.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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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. Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights is brought to the attention of residents and their families on admission to the facility. Residents confirmed their rights are being met and staff are respectful of their needs. Observation during the on-site audit confirmed communication is appropriate. Staff ensure that residents are informed and have choices related to the care they receive.

Complaints are managed and the complaints register is maintained and up to date.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Oceania Healthcare Limited is responsible for governance of this facility. The business plan and quality and risk management systems reflect the scope, direction, goals, values, and mission statement of the organisation. The organisation's mission statement and vision are displayed in the facility.

The quality and risk management system supports provision of clinical care and include systems for monitoring of service delivery. The quality management system includes an internal audit process, complaints management, resident and relative satisfaction surveys, incident and accidents, and infection control data analysis.

Corrective action planning is implemented with evidence of the resolution of issues. Quality and risk management activities and results are shared among staff. Reporting processes include external benchmarking.

The service is managed by a business and care manager who is new to the role supported by a newly appointed clinical manager, the regional clinical and quality manager and the general manager. The clinical manager is responsible for the oversight and implementation of the clinical services in the facility with the support of two clinical leaders of which one is new to their role.

There are human resource policies implemented relating to recruitment, selection, orientation and staff training and development. Staff files were reviewed with validation of annual practising certificates for staff who were employed. An in-service education programme ensures ongoing education and training opportunities for staff. Staff training registers are maintained. New staff are required to complete orientation and induction programmes. Staff have completed orientation to the care of residents in independent living units.

Interview confirmed that staffing levels are adequate. Interviews with residents and relatives demonstrated they have adequate access to staff to support residents when needed. Staff are allocated to support residents as per their individual needs. Current staffing levels will allow for the service to admit up to five rest home level residents before they will employ additional staff to adjust staffing as residents are admitted into the additional beds.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Initial assessments, care plans and evaluations are completed by a registered nurse. Families interviewed confirmed they were involved in the care planning and review process.

Medication policies reflect legislative requirements and guidelines. Medicines are stored and managed appropriately in line with legislation and guidelines. There are at least three-monthly reviews by the general practitioner. Registered nurses, enrolled nurses and senior healthcare assistants are responsible for administration of medicines and complete annual education and medication competencies.

There is a group activity programme developed and implemented in the service. Participation is encouraged and is voluntary. Activities are planned that are meaningful to the residents and the programme ensures the interests of residents are included. Community outings are arranged with entertainers and speakers invited to participate in the programme. Special consideration is given to younger people with disabilities when planning the activities programme.

At Elmwood Rest Home and Village all meals are prepared on-site. The menu plans have been reviewed by a dietitian at organisational level and are suitable for older people and/or residents with disabilities. Resident's individual food preferences, dislikes and dietary requirements are catered for.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The facility, including the independent living units, have an approved fire evacuation plan. Residents have access to the call bell system.

There is a preventative maintenance programme in place which includes equipment and electrical checks. Fixtures, fittings, floor and wall surfaces are made from appropriate materials for this environment. The independent living units provide single accommodation and are spacious enough to allow for rest home and hospital level care.

Policies for waste management, cleaning, laundry, emergency and security management are in place and procedures and processes are appropriate to provide safe services for the proposed changes in the facility.

Visual inspection during the tour of the facility provided evidence of required service areas throughout the building, including areas for safe storage of chemicals and equipment. Protective equipment and clothing are available throughout the facility. The laundry service will continue to be completed at another Oceania facility close by and cleaning services will be provided seven days per week.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint minimisation and safe practice policies and procedures record the safe use of restraints and enablers. Restraint and enabler use comply with requirements. On the days of audit, there were three residents using restraints and one resident using an enabler at the facility. Staff interviewed demonstrated an understanding of restraint and enabler use and receive ongoing restraint education.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Elmwood Rest Home and Village has an infection control programme that complies with current best practice, its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme.

One of the clinical leads is the infection control coordinator. Surveillance data is collected, collated, analysed and trends are reported to staff.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	20	0	1	4	0	0
<b>Criteria</b>	0	53	0	2	4	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>Policy and procedures identify that the organisation is committed to manage complaints effectively. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints. The facility's complaints policies and procedures are aligned with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Residents and family receive information regarding the complaints process on admission. Residents and family confirmed the business and care manager's open door policy makes it easy to discuss concerns at any time. All the complaints recorded in the complaints register were reviewed. The complaints register records the complaint, dates, corrective actions taken and when the complaint was closed out.</p> <p>A complaint to the Health and Disability Commissioner (HDC) was investigated and recommendations made for implementation by the facility to be reviewed at audit. Following review, it is noted that recommendations have not been implemented including timeliness of medical review post incident and post fall observations (refer to 1.2.4.3; 1.3.3.3) and this complaint is not closed out. The Ministry of Health required evidence of the implementation of these changes. There was evidence that the falls policy was reviewed in 2017, however, suggestion for a GP/nurse practitioner (NP) to review all residents who fall, was not adopted into this policy. Regarding observations by nursing staff; no changes were implemented (refer to tracer hospital 1.3.3.3). Regarding actions taken by nursing staff in assessing the resident after a fall; all residents who fall must have a 'post falls assessment' completed, however on review of 15 resident files of residents who had falls, two did not have post falls assessments completed (refer 1.2.4.3). The post falls assessment document has not been reviewed since the complaint to the HDC. The post falls</p>

		<p>assessment record does not currently guide/prompt staff in order for staff to be able to identify serious injury of a resident over a less serious fall. Current staff also have not had training specific to assessment, in order to recognise a serious injury after a fall, for example internal bleeding or a fractures (refer to 1.3.3.3). All residents who have un-observed fall have neurological observations recorded over a period of 24 hours and most of these residents are referred to the physiotherapist for review. This complaint remains open with the MoH</p> <p>A complaint to the district health board (DHB) regarding interRAI assessments, has been investigated and evidence of changes has been provided to the DHB and closed out by the DHB.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident and incident management processes, the complaints procedure and the open disclosure policy alert staff to their responsibility to notify family and/or enduring power of attorney of any accidents and/or incidents that occurs. These procedures guide staff on the process to ensure full and frank open disclosure was available. Clinical files reviewed evidenced timely and open communication with residents and their family members. Communication with family members is recorded in progress notes.</p> <p>The business and care manager advised that interpreter services are able to be accessed from Counties Manukau District Health Board when required. There were no residents at the facility needing interpreter services during the on-site audit.</p> <p>The information pack in large print could be sourced if needed and staff confirmed this could be read to residents. 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. Resident files evidenced all agreements were signed on the day of admission.</p> <p>The admission and welcome pack given to potential and new residents and family includes relevant and individualised information. Family meetings inform family members of facility activities and provide opportunity for family members to discuss issues and/or concerns with management.</p> <p>Interviews with residents and families confirmed their satisfaction with the services provided at this facility. The recent satisfaction survey report indicated there was satisfaction with the care and support provided.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated,</p>	FA	<p>Elmwood Rest Home and Village is part of Oceania Healthcare Limited (Oceania) with the executive management (support office) providing support to the service. The clinical and quality manager and the general manager aged care (GM) provided support to management during the audit.</p> <p>The monthly business status report provides the executive management team with progress against identified indicators. The organisation has clear values, goals and a mission statement. These are communicated to residents, staff and family through posters on the wall, information in booklets and staff orientation and training.</p>

<p>and appropriate to the needs of consumers.</p>		<p>The business and care manager (BCM) is responsible for the overall management of the service. The BCM is a registered nurse with a current annual practising certificate, who has been working in similar roles in aged care services for the previous 15 years and is new to this facility. The BCM is supported by the clinical manager (CM) and two clinical leads.</p> <p>At the time of the on-site audit, there were 61 residents receiving rest home care and 60 residents receiving hospital level care. These numbers included 10 young people with disabilities (YPD). One of the YPD residents receives care under the chronic illness contract at hospital level. Of the other nine YPD residents, seven are receiving hospital level care and two receiving rest home care.</p> <p>The service holds a rehabilitation contract for the Accident Compensation Company (ACC), a contract for long-term support for chronic illness, and respite care. At the time of the audit the service, due to the large number of YPD residents the facility was advised by HealthCERT to apply to add disabilities services to their certification. This was completed during the audit.</p> <p>Interviews with Oceania management and the BCM confirmed the plan is to begin using the reconfigured services as soon as possible.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence of the BCM, the CM, with support from the regional clinical and quality manager, is responsible for the day to day operation of services. The BCM has been in the position for six months, the CM has been in their position four months and the clinical leads (CL) have been in their positions for nearly three months. Both these staff members have worked in other facilities with the BCM for about three years prior to their appointments at this facility. The staffing plan, service management, including nursing station accessibility is appropriate for the additional dual purpose beds.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has</p>	<p>FA</p>	<p>Elmwood Rest Home and Village uses the Oceania Healthcare Limited quality and risk management framework that is documented to guide practice. The service implements organisational policies and procedures to support service delivery. Policies are current (refer to 1.2.4.3). The Oceania Healthcare Limited support office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation and evidenced based best practice guidelines.</p>

<p>an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Service delivery is monitored through review of complaints (refer to 1.1.13, 1.2.4.3 and 1.3.3.3), incidents and accidents (refer to 1.2.4.3 and 1.3.3.3), surveillance of infections, pressure injury and soft tissue/wound reviews, and implementation of an internal audit programme. Corrective action plans are documented and there is evidence of the resolution of issues. There is documentation that includes collection, collation, and identification of trends and analysis of data. Internal audits around pressure injuries are completed. InterRAI assessments are completed, however, are not completed with the required timeframes or up to date for all residents (refer to 1.3.3.3).</p> <p>There are monthly meetings including; staff/quality improvement, clinical, restraint and infection control. There are bimonthly resident meetings and family are able to attend these meetings.</p> <p>Hazards are addressed and risks minimised or isolated. Health and safety is audited throughout the year with a facility health check completed by the clinical and quality manager. If any issues are identified in the health check, a corrective action plan is put in place and evidence of the resolution of issues documented.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>The BCM is aware of situations in which the service would need to report and notify statutory authorities and that this may include police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks and changes in key managers. The Ministry of Health and district health board are notified of any sentinel event.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand the adverse event reporting process and were able to describe the importance of recording near misses. Information gathered around incidents and accidents is analysed with evidence of improvements put in place.</p> <p>There is a requirement for improvement relating to post falls assessments not being consistently completed for residents that fall, the policy on falls management, procedures for improving observations and assessments and training for staff around management of serious falls.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>FA</p>	<p>The RNs, BCM, CM and CLs all hold current annual practising certificates, along with other health practitioners involved with the service. Staff files included appointment documentation, including, signed contracts, job descriptions, reference checks and interviews. There is an appraisal process in place with staff files indicating that all have a current annual appraisals in the staff files reviewed. These existing processes will be applied to any new staff employed to as part of the recruitment process and staffing plan for the increase in beds.</p> <p>Staff complete an orientation programme. New healthcare assistants are paired with a senior healthcare assistant for shifts until they demonstrate competencies in care. Healthcare assistants confirmed their role in supporting and</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>buddying new staff. Annual competencies are completed by clinical staff. Evidence of completion of competencies is kept on staff files.</p> <p>The organisation has a mandatory education and training programme with an annual training schedule documented. Staff attendances are documented for training provided. Education and training hours are at least eight hours a year for each staff member (refer to 1.2.4.3). Staff have completed training around pressure injuries. Nine staff, including managers, have completed InterRAI assessment training. Eight of the nine staff who completed interRAI training had current competencies signed off for interRAI. The BCM is in the process of updating their competencies.</p> <p>All currently employed staff that will be allocated to work in the new wing have completed the required training and competencies. The service has two diversional therapists and physiotherapy assistant who are already working in the facility. Increased hours of work has been negotiated to facilitate additional services that will be required in the independent living units, once residents are admitted to this wing.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy is the foundation for workforce planning. 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.</p> <p>Rosters sighted reflected staffing levels meeting resident acuity and bed occupancy. Staffing has been organised to reflect the needs of hospital and rest home residents in varying wings of the hospital. The business and care manager prepares bi-weekly, roll-over staff rosters. The CM's, CLs' and BCM's offices are situated in different areas across the service to ensure clinical oversight for nurses throughout the facility. One of the CLs is responsible for oversight of hospital level care in one area of the facility and the other CL covers another part of the facility. The staffing plan for the newly developed independent living units includes RN oversight and healthcare assistants, providing care from the nurses' station in this wing.</p> <p>The BCM and regional clinical and quality manager have prepared rosters for the independent living units to ensure safe and appropriate services from appropriately qualified and skilled staff. Although the rosters are in place for commencement of service delivery in the new wing, staff who are allocated to work there, are currently working in other areas of the facility. The facility's admission and staffing plan aims to increase staffing levels incrementally with every 5 residents admitted, until all 21 additional dual purpose beds are occupied. During the on-site audit the auditors understanding was the new wing will provide dedicated Aged Related Residential Care (ARRC) services. The model of funding for the new wing has not been established yet.</p> <p>Cleaning and food services are in place. The CM's responsibility will be for all clinical services in the facility. The clinical leads will oversee different areas of the facility. The rest of the clinical team will comprise of RNs and healthcare assistants (HCA), who will be working from nurses' stations throughout the facility, including the nurse's station in the new wing.</p> <p>The BCM and clinical quality manager stated staffing levels will also be reviewed for anticipated workloads and</p>

		<p>appropriate skill mix and adjusted according to the resident numbers and their required care needs. The staffing levels in the proposed rosters comply with the specifications outlined in the ARRC Services Agreement. When non ARRC residents living in the serviced apartments, experience a change in their health status, and they are not independent anymore, the resident will be assessed by Needs Assessment Service Coordination (NASC) team to establish the level of their care needs.</p> <p>Residents and families interviewed confirmed staffing is adequate to meet the residents' needs.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by a RN. Any errors by the pharmacy are regarded as an incident and referred back to the pharmacy. All staff (RNs, enrolled nurses or senior healthcare assistants) who administer medicines have completed medication competencies. Staff attend annual medication education. Medication administration observed met legislative requirements.</p> <p>Medication areas, including drug storage areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. However, not all documentation of administration was completed in line with legislative requirements. There was evidence six monthly pharmacy checks were completed, however some medication reviewed were past the expiry date.. The fridge where medications are kept has required temperature checks completed.</p> <p>There is a dedicated medication room and equipment in the area for proposed new hospital level residents that meets all legislative requirements.</p> <p>Medication charts reviewed demonstrated medication profiles are legible, up to date, as required (PRN) medicines are correctly prescribed. Three-monthly reviews are conducted by the GP and any discontinued medicines are dated and signed by the GP. There is a policy and process that describes self-administered medicines. There is currently one resident who self-administers medications. The resident's competency is checked three-monthly and a record signed by the GP is kept on file. Young persons are supported to self-medicate if required. Standing orders meet legislative guidelines.</p> <p>The current implemented medication system is satisfactory to meet the needs of increasing numbers of dual purpose residents proposed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>A full time head cook oversees food provision at Elmwood. The head cook is supported by three cooks and five kitchen assistants across seven days. The service has a large commercial kitchen. There is a four weekly seasonal menu last reviewed by a dietitian at organisational level in August 2017. Diets are modified as required. The kitchen can cater to specific requests if needed. The service encourages residents to express their likes and dislikes. At interview, the head cook described that the RN completes each resident's nutritional profile on admission with the</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>aid of the resident and family and the kitchen is notified daily of any changes. The residents interviewed spoke highly about meals provided and they all stated that staff ask them about their food preferences.</p> <p>Meals are plated in the kitchen and delivered to wings via a hot box system to maintain correct food temperatures. Residents requiring extra support to eat and drink are assisted, this was observed during lunch.</p> <p>The kitchen and the equipment meet food safety requirements. A kitchen manual is available in the kitchen. All staff working in the kitchen had completed food safety training Food and fridge/freezer temperatures are checked and documented daily. Food in the chillers was observed to be covered and dated. The kitchen was clean and all food is stored off the floor. A cleaning schedule is maintained. Chemicals are stored appropriately.</p> <p>Food audits are carried out as per the yearly audit schedule.</p> <p>The current food service is satisfactory to accommodate an increase in dual purpose resident dietary requirements.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents' needs are assessed prior to admission. Registered nurses and healthcare assistants (HCA) follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g. to the wound care nurse specialist, physiotherapist or podiatrist). If external medical advice is required, this will be actioned by the GP or NP. Long-term care plans are completed in consultation with the resident and family/whānau where applicable. Two of three long-term care plans requiring review did not evidence at least six-monthly care plan reviews, an additional three residents files reviewed had not been at the facility long enough to require review (refer to 1.3.8.2).</p> <p>The use of short-term care plans was evident. Monitoring forms, including but not limited to, weight, observations and wounds, are in use as applicable and maintained. In files sampled wound care plans, nutrition management, fluid balance management plans and pain management plans were evident. Wound assessment and wound management plans were in place for four residents with wounds. Interview with RNs, CLs and the CM confirmed the DHB wound or continence specialist nurses are contacted when required. There is evidence in files of the wound specialist referrals and consultation with the NP.</p> <p>Staff had access to sufficient medical supplies. Continence products are available and resident files include a continence assessment and plan as part of the plan of care.</p> <p>The care being provided is consistent with the needs of residents. This is verified in discussions with residents, family and staff. The NP interviewed stated the facility implemented changes of care in a timely manner and was satisfied with the quality of service delivery provided.</p>
<p>Standard 1.3.7:</p>	<p>FA</p>	<p>Elmwood has two full time diversional therapists, with one of these DT's also a team leader. The diversional therapists provide a seven day week programme and are supported by three activities coordinators, one full time</p>

<p><b>Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>and two part time. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge. Residents can join in with any activities. There are three large lounge areas and some smaller lounge areas where residents can enjoy activities and/or quiet time.</p> <p>Residents have an assessment completed over the first few weeks after admission to ascertain their past and present interests, career and family. The two diversional therapists interviewed described participating in discussions with the RNs in preparation of the activities section of the care plan.</p> <p>Activities are age appropriate and are planned. Activities provided are meaningful and reflect ordinary patterns of life. Activities include, for example, entertainers, speakers, crafts, exercise, music/sing-a-long, bingo, movies, weekly van outings with a dedicated van driver and baking. There are also visits from community groups. Church services are held for all denominations and residents support a local charity of their choice.</p> <p>The diversional therapists interviewed also stated that they participate in six monthly multidisciplinary meetings and conduct bimonthly residents' meetings for the younger residents where activities are planned to meet the needs of these residents. There is a separate additional activities assessment for YPDs. Younger person specific activities include, but are not limited to, activities of choice, involvement with local community, and accompanying and assisting staff with various activities including preparation for special events.</p> <p>Resident and family members interviewed stated that activities are appropriate and varied enough to hold interest. All residents interviewed, stated they were happy with the activities available and are given a choice regarding attendance.</p> <p>The activities team currently provide separate activities for rest home level residents and have the resources to expand further for increasing numbers of hospital level residents.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Review of long-term care plan documentation, observations and interviews with staff and residents confirmed the residents received care according to assessed needs. There was documented evidence that not all long-term care plans had been completed in a comprehensive manner and not all long-term care plan evaluations had been completed within timeframe required or updated when there was a change in health status.</p> <p>The GP reviews residents' medication at least three-monthly or more often if issues arise or health status changes. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews. Progress notes record entries each shift and document changes in condition and outcomes of interventions. Short-term care plans are in place for acute problems. Family interviewed confirmed they are kept up to date with any changes in health condition.</p>
<p><b>Standard 1.4.1:</b></p>	<p>FA</p>	<p>The organisation's healthcare waste policy includes, but is not limited to, medical waste, soiled disposable waste,</p>

<p>Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>wet linen, sharps, body fluids/waste and equipment cleaning. The service has personal protective equipment available and displayed in the different sluice rooms and the chemical storage and cleaners' rooms. The cleaners' rooms and chemical storage rooms are locked using keys carried by the cleaners and the maintenance person.</p> <p>The BCM and clinical lead have oversight responsibility for how waste, infectious or hazardous substances are managed, including cleaning and food services also overseen by the BCM with input and additional oversight from regional managers.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>The service has a current building warrant of fitness.</p> <p>The physical environment promotes safe mobility and easy use of aids and independence. The environment also aims to minimise risk of harm, however, there is a boiling water unit providing hot water in the dining area of the new wing which could easily be reached by residents and is not appropriate to the needs of rest home and hospital level residents. This is a requirement for improvement to be implemented prior to admitting residents. All areas within the facility, including the independent living units, are connected by corridors and nurses' stations. There are several doors leading into the surrounding gardens. All external doors are alarmed as verified during on-site audit. As soon as the external doors are opened, an alarm is triggered in the nurses' station, identifying the door, and staff are able to investigate.</p> <p>The Oceania area maintenance supervisor already provides oversight, guidance and support for the maintenance person, who has been with the facility for about eight months. The service has an implemented, preventative maintenance plan in place. Hot water temperature testing evidenced temperatures are monitored and when temperatures are outside expected levels the plumber is informed and corrective actions are implemented. Electrical equipment has been checked and medical equipment had been checked and calibrated.</p> <p>Oceania hold an ACC workplace safety management practices tertiary level certification. Health and safety policies are current and company-wide. Induction processes for contractors include emergencies; workplace layout; first aid; hazards specific to the site; smoking policy; protective equipment: hazard notice board and contract reviews. Contractors are required to sign the contractors register when going on site.</p> <p>The facilities include the equipment needed to provide additional rest home and hospital level services. Communal areas included televisions and other entertainment equipment needed for providing activities.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>The 21 independent living units all have full ensuite facilities, including a toilet, shower and hand basin. The service has another 42 rest home rooms, some with a shared ensuite between two rooms and others with an ensuite toilet and hand basin and shared showering facilities. There are sufficient bathroom, toilet and shower facilities to accommodate the increase in bed numbers.</p> <p>The bathroom facilities are of an appropriate design to meet the needs of the residents. There are two visitors' toilets in the facility. All rooms are single rooms which are spacious allowing for the use of equipment and staff in the room, during service delivery.</p> <p>The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All toilets provide appropriate access for residents and bathrooms are clearly identified.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>The 21 independent living units each have a kitchenette, lounge/dining area, separate bedroom and en-suite bathroom, including a shower, toilet and hand basin. All the units are spacious and allow for personal mobility aids, additional chairs and furniture and suitable for rest home and hospital level care. The 139 rest home and hospital rooms used prior to addition of the new wing, are spacious and allow enough space for staff and equipment to provide appropriate care.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age</p>	<p>FA</p>	<p>The physical tour of the facility verified the service provides adequate and appropriate access to communal lounge, activities, visitors and dining facilities. There are opportunities for residents, their families and their visitors to meet.</p> <p>Each independent living unit has its own lounge area for residents to meet with their visitors and family in private. The service has eight communal lounges and eight dining areas throughout the facility. Young people with disabilities confirm the facility provides enough communal areas to have their personal space and privacy.</p> <p>There is an activities/diversional therapy lounge next to the reception lobby. All lounge and dining areas are large enough to accommodate the residents from each specific service area.</p>

<p>appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Interviews with management confirmed the laundry services are completed at another Oceania service. Processes are in place to ensure effective management of cleaning and laundry services to and from the other facility where laundry is cleaned. Laundry is collected and delivered on a daily basis. There are designated areas for dirty and clean laundry. The laundry process will include laundry services to the residents in the independent living units receiving rest home and hospital level care.</p> <p>Linen trollies and bags were sighted. The cleaning staff will be on site during the day, seven days a week. The Oceania internal audit schedule includes laundry and cleaning audits and these are conducted as per Oceania policies and procedures.</p> <p>Cleaning trolleys include areas where chemicals are being stored. Auditors observed sluice rooms, the cleaning and the chemical storage rooms had material safety data sheets, with guidelines for interventions when needed.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Information for the management of emergency and security situations is available and accessible for staff and residents. All staff receive information, training and equipment to respond and identify emergency and security situations. This was sighted in records confirming the trial evacuation training. Orientation/induction programme includes training on emergency and security situations. Staff who have been identified to commence work in the new wing have already completed required emergency training and orientation.</p> <p>The service has an approved fire evacuation plan, which includes an automatic sprinkler system, emergency warning system for fire and other dangers, fire doors and smoke detectors. Fire exits and signs for communicating information relating to building evacuations, are in place.</p> <p>The service completes six-monthly fire evacuation training for staff, with fire evacuation training as part of the induction and orientation programme for new staff.</p> <p>The service has emergency lighting with provision for a generator with a battery backup for emergency systems. Emergency equipment is accessible, stored and there are appropriate levels of stock to ensure the facility stays operational during an emergency, for example, an earthquake. There are torches, gas for cooking and emergency water supply.</p> <p>The service completes six-monthly fire evacuation training for staff, with fire evacuation training as part of the induction and orientation programme for new staff.</p>

		<p>The call bell system which includes call bells at all toilets, showers, beds, kitchen/lounge areas and in three different areas within the independent living units. The communal lounge and dining areas have call bells for use during emergencies.</p> <p>The BCM confirmed that reception is operational seven days a week. Contractors and visitors are required to sign the register at the entrance to the facility. Security rounds are completed by a security company who complete two checks at night. The front door locks automatically at night with a calling system, should visitors arrive after hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All areas throughout the facility are ventilated. Heat pumps and wall mounted heaters are provided throughout the facility.</p> <p>Showers have vents and extraction fans. All bedrooms, communal areas and corridors have large external windows allowing natural light into the building.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Elmwood implements the Oceania group infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The infection control committee has representatives in each area of the service management team. This group meets monthly and infection control matters are discussed at the facility monthly quality meetings (all staff). Minutes are available for staff. The infection control programme is reviewed annually at organisational level. One of the CLs is the designated infection control coordinator. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff in orientation and induction.</p> <p>The current infection control programme is suitable to meet the needs of the proposed increase in number of dual purpose residents.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal process monitoring is undertaken via the internal audit programme. The service submits data monthly to Oceania support office where benchmarking is completed.</p> <p>Infections are collated monthly, including for example, urinary tract, upper respiratory and skin. This data is analysed for trends and the raw data is reported to the quality meetings to all staff and at RN meetings.</p> <p>In January 2018 there was an outbreak recorded. This was contained with no further cases reported.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The Oceania restraint minimisation and safe practice handbook and policies comply with this standard and relevant legislation. The restraint coordinator is the CM. A signed position description was sighted. There were three residents using restraints and one resident requesting the use of an enabler during the on-site audit.</p> <p>The restraint register is maintained and current. The required documentation relating to restraint and enabler use is recorded. Documentation relating to enabler use confirmed the enablers are voluntary, requested by the residents and the least restrictive options to promote the residents' independence and safety.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA</p> <p>Moderate</p>	<p>Fifteen records of residents who had falls, including un-observed falls and falls with injury, were reviewed. Documentation showed that incident/accident records were completed, family informed and neurological observations completed for all residents who had un-observed falls. Most of the residents that had falls were also referred to the physiotherapist for assessment, however, two residents did not have a post falls assessment completed. Review of the post falls assessment record showed insufficient assessment prompts for nurses to be able to identify residents with serious injuries in a timely manner (refer to 1.3.3.3 and 1.1.13). The post falls assessment forms reviewed did not show evidence of staff having been able to identify where residents sustained serious injuries. failed to recognise/identify the one resident who sustained a serious injury (refer to 1.3.3.3).</p>	<p>i) Not all residents who fall have post falls assessments completed.</p> <p>ii) Policy and procedures in relation to falls management do not currently provide clear guidelines for nursing observations and nursing assessment to ensure serious injuries resulting from falls, are</p>	<p>i) The service to provide evidence that all residents who fall have comprehensive post falls assessments completed.</p> <p>ii) The service to provide evidence that policy and procedures include specific guidelines for appropriate nursing observations and nursing assessment to</p>

			<p>recognised and treated accordingly for residents.</p> <p>iii) Training of registered nurses does not currently include early recognition of serious injury through falls.</p>	<p>ensure residents who sustain serious injuries through falls, are recognised and treated accordingly.</p> <p>iii) The service to provide evidence of training for staff in relation to observation and assessment of residents to ensure early recognition of serious injuries through falls.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation,</p>	<p>PA</p> <p>Moderate</p>	<p>Medicines management policies and procedures are in place to guide staff. All staff administering medications have completed the required medication competencies and education. Medications are stored safely and meet legislative requirements, however, not all medications were within accepted expiry dates (e.g. two eye drop medications reviewed were past the expiry date). Medication reconciliation occurs against accepted guidelines however, review of the hospital drug register evidenced documentation requirements were not always met.</p>	<p>i) Not all medication was within expiry dates.</p> <p>ii) Weekly drug checks were not always recorded in the drug register.</p> <p>iii) Not all drugs requiring two signatures were documented as required.</p>	<p>i) Ensure all medication in use are within expiry date.</p> <p>ii) Ensure weekly drug checks are maintained and documented in the drug register.</p> <p>iii) Ensure two signatures are documented when required.</p> <p>90 days</p>

protocols, and guidelines.				
<p>Criterion 1.3.3.3</p> <p>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.</p>	<p>PA Moderate</p>	<p>All residents who were under the care of the house GP had contractual timeframes in relation to admission assessments met. The NP interviewed stated they received appropriate and timely referrals from the registered nurses.</p> <p>An initial assessment, initial care plan, interRAI assessment and long-term care plan were evidenced in all files sampled. Not all interRAI assessments and long-term care plans were completed within expected timeframes. In two resident files sampled the long-term care plan did not reflect current interventions required (refer to 1.3.8.3).</p> <p>Registered nurses are trained in interRAI assessments, however timeframes specified in the Age-Related Residential Care Services Agreement (ARRC) for interRAI assessments were not always met. Interview with managers and review of interRAI reports confirmed 40% are overdue and a corrective action plan in place. Registered nurses interviewed confirmed they are supported and are working to a plan to ensure interRAI assessments are brought up to date in the next three months.</p> <p>For one resident who had a fall with injury, requiring transfer to DHB, the post falls assessment did not identify signs of serious injury in a timely manner.</p>	<p>i) Four of six files sampled did not have a long-term care plan completed within three weeks of admission.</p> <p>ii) Three of five files sampled under the ARRC contract did not have contractual timeframes around interRAI met and not all InterRAI assessments are up to date.</p> <p>iii) The post falls assessment of a resident with a fall injury did not document all signs of the serious injury requiring assessment and treatment in a timely manner.</p>	<p>i) Ensure long term care plans are completed within three weeks of admission.</p> <p>ii) Ensure all contractual timeframes for interRAI are met and all InterRAI assessments are up to date.</p> <p>iii) Provide evidence post falls assessment is robust enough to identify serious injury requiring referral for further assessment and treatment in a timely manner.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused,</p>	<p>PA Low</p>	<p>There was evidence of care plan evaluations and multidisciplinary reviews occurring, however not all evaluations were completed comprehensively for residents and not all evaluations had been completed within appropriate timeframes.</p>	<p>Two of six resident files sampled did not document completed evaluations or</p>	<p>Ensure all evaluations are comprehensive and documented in</p>

indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.			progress towards goals.	a timely manner.  90 days
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Low	Progress notes record changes in health status, however, not all care plans are updated when changes occur.	In two of six resident files sampled the long-term care plan did not document changes that had occurred.	<p>Ensure for any change in health status, the long-term care plan is updated when those changes occur.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Moderate	The physical environment promotes safe mobility and aids independence. In the new wing with the independent living units there is provision for residents to make their own cups of tea/coffee in the dining area. Hot water is provided through the use of a boiling water unit, which is not appropriate for use by residents needing rest home and hospital level of care.	The boiling water unit in the new wing is not safe for use for residents receiving rest home and hospital level of care.	<p>Ensure residents receiving rest home and hospital level of care are in a physical environment which minimises risk of harm and is appropriate to the needs.</p> <p>Prior to occupancy days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.