

# Oceania Care Company Limited - Woodlands Rest Home and Village

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## Introduction

This report records the results of a Partial Provisional Audit; 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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Woodlands Rest Home and Village
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 19 July 2018    End date: 20 July 2018
<b>Proposed changes to current services (if any):</b>	The HealthCERT letter dated 10 July 2018 requested the review of the reduction of 15 rest home rooms to 10 dual purpose care suites.

TAS auditors reviewed on-site the reduction of 16 rest home rooms to 10 dual purpose care suites. The proposed change to total licenced bed numbers reviewed on-site was as stated in the HealthCERT letter, with a decrease from 62 to 56 beds comprising of 16 hospital beds, 24 dual purpose beds, 9 rest home beds and 7 dementia beds.

**Total beds occupied across all premises included in the audit on the first day of the audit: 45**

# 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

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards. The facility is currently in the process of reducing their capacity by converting 1 wing of single rest home rooms into 10 larger dual purpose rooms that includes a dedicated medication room and equipment room. These rooms in this wing will be available to residents as occupational right agreement rooms. A partial provisional audit was also undertaken to establish the level of preparedness to provide services in a reconfigured facility that has 24 dual purpose beds for residents at hospital and rest home levels of care. The facility has sufficient available beds to accommodate all current residents and no resident has been displaced throughout the reconfiguration. The facility provides residential care for up to 63 residents and occupancy on the day of the audit was 45.

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

There are areas identified as requiring improvement relating to interRAI assessments; medication reviews and firefighting equipment.

## 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; complaints process and Nationwide Health and Disability Advocacy Service, is provided to residents and their families on admission to the facility. Residents' cultural and spiritual beliefs are identified on admission and there is access to cultural and spiritual support if required.

Residents and family confirmed that their rights are being met, staff are respectful of their needs and communication is appropriate.

There is a documented complaints management system and a register of complaints is maintained. The complaints reviewed were investigated, with documentation completed and stored in the complaints folder.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Oceania Healthcare Limited is the governing body responsible for the services provided at Woodlands Rest Home and Village. The business and care manager is responsible for the overall management of the facility. The business and care manager is a registered nurse who is suitably qualified and experienced and has been in the role for 14 months. The business and care manager is supported by a clinical manager and the regional and executive management team. The clinical manager is a registered nurse and is responsible for clinical management and oversight of services and is supported by the regional clinical quality manager.

There have been no changes to the staffing structure or systems since the previous audit.

A business plan documents the scope, direction, goals, values and mission statement of the facility.

There is a quality and risk management system that supports the provision of clinical care and quality improvement. Policies are reviewed nationally. Quality and risk performance is reported through staff and quality improvement meetings at the facility and monthly reports to the national support office allow for benchmarking and the monitoring of service delivery. Benchmarking reports include clinical indicators, incidents/accidents, infections and complaints. An internal audit programme is implemented. Corrective action plans are documented and there is evidence of the resolution of issues when these are identified. There is an electronic database to record risk in which risks and controls are clearly documented.

A review of staff files and training records confirmed that policies and procedures to guide human resource management are implemented. Recruitment and employment practices are in line with legislative requirements and registration with professional bodies is verified annually for all staff who require these. A training plan is implemented and in-service education is provided for all staff, including mandatory training around clinical service delivery. Staff competency is routinely assessed.

Staffing levels are sufficient across the facility. Registered nurses are on duty twenty-four hours a day seven days a week and are supported by adequate levels of care and allied health staff. There are at least two staff on duty at all times with a current first aid certificate.

## 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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The business and care manager has primary responsibility for managing entry to the service with support from the clinical manager and the registered nurse.

Residents receive services from staff who are suitably experienced and qualified. Assessments are completed through the use of interRAI. The initial assessments, the initial care plans and the short-term care plans for acute conditions are conducted within the required timeframes. Person centred care plan evaluations are documented and resident-focused. The residents and family members have an opportunity to contribute to care plans and evaluations of care.

Medication policies reflect legislative requirements and guidelines. Medicines are stored appropriately in line with legislation and guidelines. Registered 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 for each service. The activity programme includes meaningful activities that meet the recreational needs and preferences of the residents.

At Woodlands Rest Home and Village all meals are prepared on-site. Residents' individual food preferences, dislikes and dietary requirements are catered for.

## 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.		Some standards applicable to this service partially attained and of low risk.
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There is a current building warrant of fitness. A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes equipment and electrical checks.

The facility is in the process of a re-purposing and refurbishing rooms with areas being vacated and a temporary access corridor has been installed during this project. One half of one rest home wing has been converted into five dual purpose rooms and the conversion of the second half of the wing into a further five dual purpose rooms is in progress. The 10 proposed dual purpose rooms (5 of which are currently occupied by residents assessed at rest home level) have sufficient room for mobility access and staff; an ensuite; a kitchenette; heating and external light and ventilation. The rooms currently occupied by residents are fit for purpose.

The facility has one other room with an ensuite bathroom. Bathroom and showering facilities are provided throughout the facility and are easily accessible. Residents' rooms are spacious enough to allow for the safe and easy use of mobility aids and staff. There is a whānau room; several lounges; and external areas providing seating and shade. The facility has a monitored call bell systems for residents to summon help, when needed, in a timely manner. Essential security systems are in place to ensure resident safety with six monthly trial evacuations undertaken.

There are documented and implemented policies and procedures for cleaning and waste management. Staff receive training to ensure the safe handling of waste and hazardous substances, and are familiar with the requirements for safe handling.

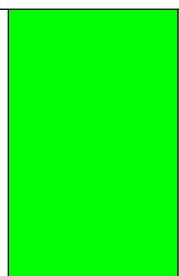
There was evidence sighted of: adequate sluice facilities, cleaning and laundry; safe storage of chemicals and equipment; and correct use of protective equipment and clothing. All laundry services are undertaken offsite. Cleaning and laundry services are monitored through the internal audit programme.

## 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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Policies and procedures comply with the standard for restraint minimisation and safe practice. The restraint minimisation programme defines the use of restraints and enablers. Restraint minimisation is practiced and overseen by the clinical manager. The service has a current, up-to-date restraint register. There was one resident using two different forms of restraint and there were no enablers in use on audit days.

## Infection prevention and control

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

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. Staff demonstrated adherence to accepted good practice principles around infection control.

Specialist infection prevention and control advice can be accessed from the district health board; microbiologist, general practitioners and infection control specialists if needed.

The clinical manager is the infection control coordinator. Aged residential care specific infection surveillance is undertaken, analysed, trended and results are reported to management and 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)
Standards	0	46	0	2	1	0	0
Criteria	0	98	0	2	1	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>There are implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>All staff have received education on the Code as part of orientation and the annual mandatory education module and staff interviews confirmed their understanding of the Code and their obligations. Evidence that the Code is implemented in their everyday practice includes maintaining residents' privacy; providing residents with choices; encouraging independence; involving residents/family/enduring power of attorney (EPOA) in decision making and ensuring residents are able to practise their own personal values and beliefs.</p> <p>Residents and family interviews and observation confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff are respectful towards residents and their families and residents receive information relevant to their needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their</p>	FA	<p>The organisation has an informed consent policy and procedure to ensure staff members adhere to the legal and ethical requirements of informed consent and informed choice for</p>

<p>family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>health care services and service provision. The policy describes what consent involves and how it may be obtained. The policy and procedure includes guidelines for consent for resuscitation/advance directives and resuscitation orders are completed for residents when applicable.</p> <p>The information pack provided on admission includes information regarding informed consent and the BCM or CM discuss this with residents and their families/EPOA during the admission process to ensure understanding.</p> <p>Staff interviews confirmed they are aware of the informed consent process; they ensure that residents are fully aware of treatment and interventions planned for them; they include the resident and/or family/EPOA in the planning of that care; and ensure informed consent is obtained before any treatment or intervention. Residents' files and interviews confirmed that informed consent is obtained.</p> <p>There is an advanced directives and end of life policy to ensure appropriate ethical concepts are upheld in resident treatment and care situations in relation to end of life. The policy defines the procedure for obtaining an advance directive and who may or may not make an advance directive. File reviews demonstrate that advance directives were completed in accordance with policy.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There is policy and procedure for staff to follow to ensure that residents and their families have a right to be represented and express views or concerns about their situation. It includes making them aware of the availability of advocacy services. Information regarding the availability of the Nationwide Health and Disability Advocacy Service is provided in the information packs provided to residents and family/EPOA on admission to the facility. Additional advocacy services brochures are also available in resident areas in the facility. The complaints policy also includes making residents aware of their right to advocacy when making a complaint.</p> <p>Family and resident interviews confirmed that the facility provides opportunities for the family/EPOA to be involved in decisions, they are aware of the right to advocacy and they are familiar with the advocacy services available.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with</p>	<p>FA</p>	<p>Observation and resident and staff interviews confirmed that residents may have access to visitors of their choice at any time. There are sufficient areas both inside and outside the facility for a resident and family to meet and socialise in private. Observation and interviews</p>

<p>their family/whānau and their community.</p>		<p>confirmed that families were made to feel welcome in the facility.</p> <p>Residents are encouraged to maintain existing community involvement with family and social networks. Resident interviews confirmed that residents are free to leave the facility when they so choose, for example, to attend appointments, social functions and family outings. Residents' files and the content of care plans include regular outings and external appointments.</p>
<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>There is an implemented complaints policy and associated procedures that are in line with the Code and include timeframes for responding to a complaint. Complaint forms are available in resident areas of the facility. 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.</p> <p>Evidence relating to each lodged complaint is held in the complaints folder and register. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner.</p> <p>The BCM is responsible for managing complaints. Residents and family interviews confirmed that they were aware of a complaints process and that they could make a complaint. They stated that any issues raised are dealt with effectively and efficiently. Staff interviews confirmed that when they suspected that a resident was dissatisfied with an aspect of service they would, where appropriate, encourage them to complete a complaint form. Residents and family interviews confirmed an understanding of their rights to advocacy and how to access advocacy services particularly in relation to the complaints process.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and their families are provided with information about the Code on entry to the facility in the information pack. As part of the admission process, the business care manager (BCM) or the clinical manager (CM) also explain the Code to ensure understanding. The pack includes information on the complaints process and advocacy service. The Code and associated information is also available in information brochures which are displayed in resident areas in the facility and available to take away and read in private.</p> <p>Information on the Code is also displayed in posters in English and te reo Māori. Resident</p>

		and family interviews confirmed that they are provided with information on their rights and are aware that they can access advocacy services.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code and ensure that a resident's right to privacy and dignity is upheld.</p> <p>Staff were observed to knock on bedroom doors prior to entering rooms and ensure doors are shut when cares of a personal nature were being provided. Interviews confirmed that conversations of a private or personal nature were held in the resident's room and not in public areas. Residents and families stated that they felt that resident privacy is respected.</p> <p>The organisation has a policy on sexuality and intimacy to ensure that staff understand to respond adequately to a resident's expressions of sexuality. It includes: identifying resident needs; and responding to expressions of sexuality.</p> <p>Resident files, interviews and satisfaction surveys confirmed that cultural and/or spiritual values and individual preferences are identified and upheld.</p> <p>There are policy and guidelines for staff on abuse and neglect prevention and management. Staff receive orientation and annual mandatory training on abuse and neglect and are aware of their obligations to report any incidences of suspected abuse. There are no documented incidents of abuse or neglect. Staff, resident, and family interviews confirmed that there was no evidence of abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The organisation has a Māori health plan/policy that demonstrates Oceania Healthcare Limited's commitment to respecting the cultural, values and needs of residents identifying as Māori and acknowledges the Treaty of Waitangi. There is also a cultural competency policy that describes for staff how culturally competent services should be delivered.</p> <p>Support for staff in providing culturally appropriate care, and for Māori residents and their families, can be sourced if required. Staff receive training in Māori health and cultural safety at orientation and also as part of the mandatory annual education module. There was one resident identifying as Māori at the time of audit.</p> <p>A review of residents' files confirmed that specific cultural needs are identified in the residents' care plans. Staff interview were able to describe how culturally competent services would be delivered and were aware of the importance of the involvement of</p>

		whānau in the delivery of care for Māori residents.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family/EPOA are involved in the assessment and the care planning processes.</p> <p>Information gathered during assessment includes identifying a resident's specific cultural needs, spiritual values, and beliefs. Any specific cultural needs identified in assessments are addressed in care planning. Activities assessments also include obtaining background information on a resident's spiritual and cultural preferences, which includes but is not limited to, beliefs; cultural identity; and church attendances. Activities are tailored to need identified need and preferences.</p> <p>Resident interviews and surveys confirmed that the services were responsive to individual resident's cultural needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There is policy to ensure the environment is free of discrimination, coercion; harassment; and financial exploitation for residents. The policy describes for staff how this will be prevented and where suspected reported.</p> <p>Job descriptions include the responsibilities of the position including ethical issues relevant to the role. Staff interviews confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation.</p> <p>There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination, coercion, harassment or exploitation.</p> <p>Staff mandatory training includes professional boundaries and resident and family interviews confirmed that staff maintain appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The facility implements the Oceania Healthcare Limited (Oceania) policies and procedures which are current and based on good practice, current legislation and guidelines. The policies align with the Health and Disability Services Standards and ensure safe, current evidence based practice. There is a training programme for all staff. Interviews and training programmes reviewed, confirmed that staff have access to external specialist educators, such as DHB training, palliative care, and wound care as part of the annual training and</p>

		<p>development programme. The BCM has recently completed management training.</p> <p>The organisation's quality framework includes an internal audit programme to confirm adherence to policy and good practice. Benchmarking occurs across all the Oceania facilities.</p> <p>Resident and family interviews, resident notes and observation of service delivery confirmed that resident care was based on good practice guidelines.</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>There is an open disclosure policy that provides the procedure to guide staff to ensure there is open disclosure of any adverse event where a resident has suffered any unintended harm while receiving care. Completed incident forms and resident records demonstrated that family/EPOA are informed if the resident has an incident/accident; a change in health or a change in needs. Family contact is recorded in residents' files and on the incident form.</p> <p>Family and resident interviews confirmed that family are informed of any changes in resident status and that they are invited to the care planning meetings for the resident. Family/EPOA are also welcome to attend the residents' meetings.</p> <p>There is policy that provides guidance for staff on how to access interpreter services and states staff are to access translation and interpreter services for residents if required. At the time of the audit there were no residents who required an interpreter.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The facility is part of the Oceania group with the executive management team providing support to the facility. Communication between the service and managers occurs monthly with the clinical and quality manager providing support during the audit. The monthly business status report provides the executive management with progress against identified indicators.</p> <p>In addition to the overarching Oceania business plan, the facility has a business plan specific to Woodlands. The organisation's mission statement and philosophy are displayed in the facility, detailed in information booklets provided to new residents and included in the staff training provided annually.</p> <p>The service has a BCM supported by a CM. The BCM is a registered nurse (RN) with a current practising certificate who has been in the position for 14 months. The BCM has previous experience as a CM at another facility and over 23 years' experience in aged care. The clinical care at the facility is overseen by the CM. The CM is a RN and has been in this</p>

		<p>position for approximately 12 months and has previous experience in another Oceania facility. The management team is supported in their roles by the Oceania executive and regional teams and have completed induction and orientation appropriate to their respective roles.</p> <p>Woodlands is certified to provide rest home, hospital and dementia level care and currently provides care for up to 63 residents with 45 beds occupied at the time of the audit. Occupancy included 22 residents requiring rest home level care; 10 requiring hospital level care and 7 requiring dementia care. The reconfiguration that is currently in progress is the conversion of 1 wing of single rest home rooms into 10 larger dual purpose rooms. This will reduce the total available beds to 56 beds comprised of 16 hospital beds, 24 dual purpose beds, 9 rest home beds and 7 dementia beds.</p> <p>The facility also holds district health board (DHB) contracts for respite care; palliative care and day care. There were 9 people under the day care contract and no residents under palliative or respite contracts.</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 is responsible for the day to day operation of the service and is supported by a senior RN, the regional clinical and quality manager and the regional operations manager.</p> <p>In the absence of the CM, the BCM with the support and help of the regional clinical and quality manager, ensures continuity of clinical services.</p> <p>In the advent of a longer term of absence of either the BCM or the CM a temporary appointment may be sourced through Oceania. Support is also available from another Oceania facility in the area.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The facility utilises Oceania's documented quality and risk management framework that is available to staff to guide service delivery. All policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies are presented to staff to read and sign to evidence that they have read and understood the policy. Policy updates are also provided a part of relevant in-service education. Staff confirmed that they are advised of updated policies.</p> <p>The service delivery is monitored through number of clinical indicators such as: complaints; incidents and accidents; surveillance of infections; pressure injuries; falls; medication errors</p>

		<p>and implementation of an internal audit programme. There is evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data provides evidence that data is being collected, collated and analysed to identify trends. Where required, corrective action plans are developed, implemented and evaluated. There is communication with all staff of any subsequent changes to procedures and practice through meetings, and for any changes requiring immediate notification via the staff electronic login system.</p> <p>Residents and family/EPOA are notified of updates through the facility's resident meetings. Quality and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. Staff reported that they are kept informed of quality improvements. Copies of meeting minutes are available for review in the staff room for staff that were unable to attend a meeting.</p> <p>Satisfaction surveys for residents and family/EPOA are completed as part of the internal audit programme and these evidenced satisfaction with services provided and this was confirmed by resident and family interviews.</p> <p>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 quarterly auditing of health and safety systems against the Health and Disability Sector Standards core standards as well as monthly internal auditing as part of the annual internal audit programme.</p> <p>There are nominated health and safety representatives and interview confirmed an understanding of the obligations of the role. There is evidence of hazard identification forms completed when a hazard is identified and a current hazard register is available that is reviewed and updated annually or when a new hazard is identified. Hazards are addressed or risks minimised or isolated.</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>FA</p>	<p>The BCM is aware of situations which require the facility to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles and there is evidence of correct and accurate reporting.</p> <p>The facility has reported the appointment of the CM and a norovirus outbreak to the MoH. There is one unexpected death that has been referred to the coroner and is not yet closed out.</p> <p>There is an implement accident/incident reporting process and incident reporting forms are</p>

		<p>available throughout the facility. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on an accident/incident form which is signed off by the BCM. There is evidence of a corresponding note in the resident progress notes and notification of the resident's next of kin or EPOA where appropriate.</p> <p>Adverse event reporting occurs nationally through Oceania. Results of accident/incident data is benchmarked nationally with other Oceania facilities and trends are analysed. Accident/incidents are also discussed at quarterly regional cluster meetings. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared at monthly meetings.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions. Staff files reviewed demonstrate that recruitment processes for all staff include: reference checks; a signed employment agreement; position specific job description; police vetting; photo identification and drug testing.</p> <p>Professional qualifications are validated and current copies of annual practising certificates were evidenced for all staff that require them.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks, including personal cares. Care staff confirmed their role in supporting and buddying new staff.</p> <p>The organisation has a role specific annual mandatory education and training module and a documented annual training schedule. There are systems and processes in place, including a competency register, to ensure that all staff complete their required mandatory training modules and competencies. Staff working in the dementia unit undertaken training specific to their role. Staff are also supported to complete relevant education via external education providers on topics such as palliative care and infection control. Individual staff attendance records and education session attendance records evidenced that ongoing education is provided.</p> <p>Seven RNs have completed interRAI assessments training and competencies and one is in the process of completing this. Annual competencies are completed by care staff, for example: hoist use; oxygen use; hand washing; wound management; medication management; and moving and handling. All staff have undertaken at least eight hours education and training hours per annum. The RNs' training records reviewed evidenced</p>

		<p>eight to thirty hours of relevant training.</p> <p>An appraisal schedule is in place and all staff files reviewed evidenced current staff appraisals.</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>	FA	<p>The staffing policy provides guidance to ensure safe staffing levels within the facility to meet the needs of residents' acuity. Rosters are formulated five weeks in advance and staffing levels are reviewed to accommodate anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. There are sufficient RNs and health care assistants (HCA), available to be rostered, to accommodate increases in workloads and acuity of residents such as additional hospital level residents. Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy.</p> <p>There are 60 staff, including the management team, administration, clinical staff, diversional therapist, and household staff. A review of rosters demonstrated that there are at least two RNs on each shift. The BCM and CM are on call after hours, seven days a week.</p> <p>Observation of service delivery confirmed that resident needs were being met in a timely manner. Residents and family interviews stated that staffing is adequate to meet the residents' needs and staff confirm that they have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All resident information is maintained in a separate uniquely identifiable record and this includes information obtained on admission, with input from the resident and/or resident's family/EPOA where applicable.</p> <p>There are policies and procedures in place to ensure privacy and confidentiality of resident information. Staff interviews confirmed the awareness of obligations and procedures for maintaining confidentiality of resident information. Resident care and support information can be accessed in a timely manner and when not in use is protected from unauthorised access by being locked in a cabinet in a locked office. Archived records are securely stored and easily retrievable. Documents containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel</p>

		<p>only.</p> <p>Resident records are maintained in hardcopy and information, including progress notes, is entered into the resident record in an accurate and timely manner and identifies the name and designation of the person making the entry.</p>
<p><b>Standard 1.3.1: Entry To Services</b></p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' entry processes into the service are recorded and implemented. Needs assessments are completed for rest home, hospital and dementia levels of care. The organisational information pack is available for residents and their family on admission. The admission agreement defines the scope of the service, includes all contractual requirements and evidenced resident and/or family sign off. Interviews with residents and family and review of records confirmed the admission process was completed by staff in a timely manner and new residents and their families receive sufficient information prior to and on entry to the service.</p>
<p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b></p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and coordinated manner.</p> <p>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.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>There are policies and procedures that describe medication management that align with accepted guidelines. Medications reconciliation occurs on admission when medicines are checked against the doctor's prescription and when medicines arrive from the pharmacy. This safety check is performed by the RNs. All staff (RNs and senior HCAs) who administer medicines have completed medication competencies. Staff attend annual medicines management education. The medicines management round observed met legislative requirements.</p> <p>Medication areas, including 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 medicines reviews was completed in line with legislative requirements. There was evidence six monthly pharmacy checks were completed. The fridge where medications are kept has required temperature checks</p>

		<p>completed. Residents self-administering medicines do so in accordance with policy and have three-monthly competency checks. The service does not use standard medicines orders.</p> <p>There is a dedicated medication room and equipment in the area for the proposed new occupation right agreement (ORA) units that meets all legislative requirements.</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>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food provision is overseen by the kitchen manager. The food service is provided on site. The kitchen and equipment are well maintained. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. There is a four weekly seasonal menu last reviewed by a dietitian at organisational level in August 2017.</p> <p>Food temperatures are documented within accepted range. The kitchen staff have completed all relevant food safety training.</p> <p>At interview, the kitchen manager reported that the RN completes each resident`s nutritional profile on admission with the aid of the resident and family. The kitchen can cater to specific needs as requested and diets are modified as required. The service encourages residents to express their likes and dislikes.</p> <p>The system for informing the cook about all residents` dietary needs is not currently evidenced in the kitchen. Residents requiring extra support to eat and drink are assisted. This was observed during lunch. The residents interviewed spoke highly about meals provided and they all stated that staff ask them about their food preferences.</p> <p>Cleaning schedules are maintained and chemicals used in the kitchen 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 1.3.2: Declining Referral/Entry To Services</p>	<p>FA</p>	<p>There is a process in place to inform residents and family of the reasons why services had been declined, should this occur. When residents are declined access to the service;</p>

<p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>residents and their family, the referral agency and/or the GP are informed of the decline to entry. The residents would be declined entry if not within the scope of the service or if a bed was not available. The local needs assessment and service coordination (NASC) coordinator is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>A nursing assessment completed within 24 hours of admission informs the initial care plan. Over the following three weeks the residents' needs, outcomes and goals are identified through the interRAI assessment process and informs the PCCP. Assessments are recorded, reflecting data from a range of sources, including the resident; family; GP; specialist and the referrer. Policies and protocols are in place to ensure continuity of service delivery. Nutrition and pain are assessed on admission and as needed and weights and general observations are monitored on a weekly to monthly basis dependant on needs.</p> <p>Wound assessment and wound management plans were in place. All wounds are assessed, reviewed, photographed and managed within the stated timeframes. The CM stated that they can access the DHB wound or continence specialist nurse if required.</p> <p>Assessment process and the outcomes are communicated to staff at shift handovers, communication books, progress notes, initial assessment and care plans.</p> <p>The service has appropriate resources and equipment. The assessments are conducted in a safe and appropriate environment, usually the resident's room. Interviews with residents and family confirmed their involvement in the assessments, care planning, review, treatment and evaluation of care.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Residents' PCCP's are completed within the required timeframes. Interviews confirmed that the interRAI assessment forms the basis for the PCCP. Level of needs identified through the interRAI assessment process are not accurately reflected in the PCCP. For example, where the interRAI assessment identifies a resident as having a high risk of falls, the PCCP may state that the resident is at risk of falling, not including the level of risk for the resident and therefore not including the additional interventions which should be in place for people who are at high risk of falling.</p> <p>The short-term care plans are developed for the management of acute problems, when required, and signed off by the CM when problems are resolved. Interviews with residents and families confirmed they have input into their care planning and review.</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>The care provided is consistent with residents' needs and desired outcomes (refer to 1.3.5.2). Registered nurses and HCAs follow the care plan and report progress against the care plan each shift at handover. This is evidenced by review of documentation, observation and interviews with residents, family and staff. There is evidence of referrals to specialist services such as podiatry, physiotherapy, nutritional, district nurses and DHB nurse specialists. There is also evidence of residents having access to community services.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p> <p>Residents and family/whānau members expressed satisfaction with the care provided.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Woodlands Rest Home and Village has a full time diversional therapist and activities coordinator implementing the activities programmes in the service. Activities are provided seven days a week. Residents were observed being actively involved with a variety of activities. Residents can join in with any activities. There are two areas where residents can enjoy activities and additional areas for residents and or their visitors to have quiet time.</p> <p>Residents have an activities assessment completed over the first three weeks after admission to ascertain their past and present interests, career and family. The diversional therapist 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 for example; entertainers, speakers, crafts, exercise, music/sing-a-long, bingo, movies and van outings. Church services are held for all denominations.</p> <p>The diversional therapist interviewed also stated that they participate in six monthly multidisciplinary meetings and conduct bi-monthly residents' meetings. There is a separate additional activities assessment for young people with disabilities (YPD), should they ever admit YPDs.</p> <p>Resident and family members interviewed stated that activities are appropriate and varied enough to hold their interest. All residents interviewed, stated they were happy with the activities available and they are given a choice regarding attendance.</p> <p>The activities team currently provide separate activities for rest home, hospital and dementia</p>

		<p>level of care residents.</p> <p>Residents with dementia have 24 hour activity plans for the management of challenging behaviour. Staff confirmed they know and understand what interventions are needed should a resident present with challenging behaviour.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Review of the PCCPs, and observations and interviews with staff and residents confirmed the residents receive care according to assessed needs (refer to 1.3.5.2).</p> <p>The GP reviews residents' medication (refer to 1.3.12.1).</p> <p>In interviews, residents and families 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.</p> <p>Short-term care plans are in place for acute problems. Families interviewed confirmed they are informed of changes that occur in residents' health conditions.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service has processes in place to provide opportunities for residents to choose when accessing or when being referred to other health and/or disability services. The service facilitates this access to other medical and non-medical services. The family communication sheets, located in the residents' files, confirmed family involvement.</p> <p>The service has a multidisciplinary team approach. Progress notes and communication records confirmed residents and their families are advised of their options to access other health and disability services.</p>
<p>Standard 1.4.1: 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>	FA	<p>Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling and disposal of and collecting waste. The hazard register is available and current.</p> <p>Current material safety data sheets are available and accessible to staff throughout the facility. Staff receive training and education in safe and appropriate handling of waste and hazardous substances.</p> <p>There is the provision of and availability of personal protective clothing and equipment is</p>

		provided, such as aprons, gloves and masks that is appropriate to the recognised risks. Protective clothing and equipment was observed to be used correctly in all high-risk areas.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are sufficient numbers of accessible toilets and showering facilities of appropriate design to meet resident needs located in each wing of the facility. Communal toilets have a system to indicate vacancy and have sufficient disability access. Visitor toilets are conveniently located near communal areas. Currently one rest home room and five occupied new dual purpose rooms which have ensuite toilet/shower facilities.</p> <p>All shower and toilet facilities have: call bells; and sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence. Residents were observed being supported to access communal toilets and showers in a manner that was respectful and preserved resident dignity.</p> <p>Hot water temperatures are monitored monthly and were noted to be maintained within recommended temperature ranges, Interviews with the maintenance person confirmed that where these varied from the recommend range corrective actions were taken immediately to address this.</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>	FA	<p>Residents have their own room and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Resident interviews confirmed that there was sufficient space to accommodate furniture; equipment; and staff as required. The new refurbished rooms that are proposed to be used as dual purpose rooms are spacious enough to provide hospital level of care.</p> <p>Residents and their families are encouraged to personalise their rooms. Residents' rooms viewed were personalised with their own furniture; possessions and memorabilia.</p> <p>There are designated areas to store equipment such as mobility aids, wheel chairs and walking frames safely and tidily.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to</p>	FA	<p>The facility has: three dining rooms; four lounges; and one whānau room. There are external areas with seating and shade. All areas can be easily accessed by residents and staff and there are sufficient quiet areas for residents and their visitors to access if they wish.</p> <p>Furniture in residents' rooms: includes residents' own personal pieces; is appropriate to the</p>

<p>meet their relaxation, activity, and dining needs.</p>		<p>setting; and is arranged in a manner that enable residents to mobilise freely. The lounge areas can be used for activities.</p> <p>Residents are encouraged to have meals with other residents in communal dining rooms and can choose to have their meals in their room if they wish.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken off-site at another facility. This includes laundering of residents' personal clothing that is required to be labelled as a part of the admission agreement. There are processes in place for the daily collection, transportation and delivery of linen and residents' personal clothing. There is clear delineation and observation of clean and dirty areas in the laundry.</p> <p>There are cleaners on duty each day, seven days a week and cleaning duties and procedures are clearly documented, to ensure correct cleaning processes occur. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemical on a trolley when cleaning and cleaners are aware of the need to keep the trolley with them at all times.</p> <p>The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Resident interviews and observation noted the facility to be clean and tidy.</p>
<p><b>Standard 1.4.7: Essential, Emergency, And Security Systems</b></p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>Staff files and training records demonstrate that orientation and the annual training programme includes emergency and disaster procedures and fire safety.</p> <p>An approved fire evacuation plan was sighted that is relevant to the current configuration of the facility and the refurbishment of the one wing has not resulted in changes that have impacted on the evacuation plan. Interviews and documentation confirmed that fire drills are conducted at least six monthly. There is sufficient firefighting equipment and signage displayed. The RNs on duty are the nominated fire wardens for the facility.</p> <p>Registered nurses, the cook and diversional therapist are required to complete first aid training and there are at least two staff members on each shift with a current first aid certificate.</p> <p>There are sufficient supplies to sustain staff and residents in an emergency situation including alternative energy and utility sources that are available in the event of the main supplies failing. These include a barbeque and gas bottles; a generator; lighting; and</p>

		<p>sufficient food, water, continence supplies.</p> <p>There are call bells to summon assistance in all resident rooms, including the new ORA rooms, toilets and communal areas. Call bells are checked monthly by the maintenance person and there is an alert systems to advise the BCM if a call bell has not been responded to within three minutes. Observation on the days of the audit and resident and family interviews confirmed that call bells are answered promptly.</p> <p>There are security systems in place to ensure the protection and safety of residents, visitors and staff. The facility is locked in the evenings and at night and external doors are checked by the RN at the beginning of the afternoon and nights shifts. There is night time security lighting in place. A security company periodically patrols the facility grounds in the evenings and at night and can be called for assistance if needed. In addition there is a panic alarm for staff to summon urgent assistance in emergencies.</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 resident rooms and communal areas accessed by residents have safe ventilation and external windows providing natural light. There is underfloor heating in the areas existing facility rooms used by residents. Underfloor heating has been replaced by heat pumps in place in the 10 reconfigured dual purpose rooms. The environment in both areas was noted to be maintained at a satisfactory temperature.</p> <p>There are systems in place to obtain feedback on the comfort and temperature of the environment and where practical the facility is responsive to resident feedback on heating and ventilation. Resident and family interviews confirmed that their environment was maintained at a comfortable temperature and there were no issues identified with the temperature of the facility.</p> <p>There is a designated smoking area for residents that ensures smoking does not impact on other residents or staff.</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>Woodlands Rest Home and Village 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.</p> <p>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. Minutes are available for staff.</p>

		<p>The infection control programme is reviewed annually at organisational level. The CM is the designated infection control coordinator. Internal 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 residents with the proposed increase in the number of dual purpose beds.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has access to relevant and current information, appropriate to the size and complexity of this service.</p> <p>Infection control is an agenda item at the facility's staff meetings, evidenced during review of meeting minutes and interviews with staff. The internal audit programme includes infection control audits to monitor the implementation of the infection control programme.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	<p>The infection control policies and procedures manual provide information and resources to inform staff on infection prevention and control. The policies and procedures comply with relevant legislation and current accepted good practice and are reviewed regularly.</p> <p>Staff were observed performing hand hygiene and using required products for infection control. Interviewed staff reported that there are adequate infection control resources and equipment for use. Interviewed staff demonstrated awareness of infection control procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control education is provided to all staff. Infection control forms part staff orientation and education occurs as part of the ongoing in-service education programme. Interviews with staff advised that clinical staff identify situations where infection control education is required for a resident, including hand hygiene and cough etiquette.</p> <p>The CM has completed additional training for the role as the infection control coordinator. The infection control staff education is provided by support office, the CM and external specialists. Education sessions have evidence of staff attendance/participation and content of the presentations. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews.</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>	FA	<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 July 2017 there was a norovirus 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>	FA	<p>The Oceania restraint minimisation and safe practice handbook and policies comply with this standard and relevant legislation.</p> <p>There was one resident using two different forms of restraint and no residents using enablers during the on-site audit.</p> <p>Documentation relating to enabler use confirmed that when residents request enabler use, it is a voluntary process, requested by the residents and the least restrictive option to promote the residents' independence and safety.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The service has policies and procedures in place to guide staff in the management of restraints. The restraint coordinator is the CM and a signed position description was sighted.</p> <p>The restraint register was current and maintained by the restraint coordinator. The required documentation relating to restraint and previous enabler use is recorded.</p> <p>The restraint approval process is being followed and current consents were in place for the use of restraint.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in</p>	FA	<p>Residents' records reviewed for restraint confirmed all restraint processes meet the standard.</p> <p>The restraint consent records include opportunity to record restraint risks. Identified risks are</p>

relation to use of restraint.		specific to the type of restraint used. Culturally safe practice was maintained throughout restraint/enabler use, as identified in the PCCPs.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The service uses an assessment process specific to the needs of the residents. Review of restraint management showed that restraint assessments are consistently completed and reviewed. The restraints used at the facility are bedrails and lap belts.</p> <p>Interviews with staff and review of long-term care plans confirmed alternatives to restraint use is considered prior to commencing restraint. Staff complete annual restraint competency training.</p> <p>Staff are aware that advocacy services and support are available, the contact details are documented, and the services can be accessed when needed to inform residents and their families about advocacy.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Interviews with an RN and CM confirmed evaluations of the restraints are completed at three-monthly intervals. Evaluation and review of restraints were reviewed.</p> <p>Interviews with the RN, CM and the GP confirmed their roles in the restraint review process. The restraint coordinator and RNs confirmed communication with families regarding restraint and enabler use.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	<p>The restraint coordinator reports on restraint management at monthly meetings.</p> <p>Interviews confirmed that the restraint approval process forms part of the three monthly medical review. Interviews confirmed that the review of restraints include effectiveness of the restraint, compliance with policy and procedures, adverse events related to restraint and reviewing possibilities of discontinuing restraint use where appropriate.</p> <p>Education records sighted evidenced staff received education on restraint minimisation and safe practice.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</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, protocols, and guidelines.</p>	PA Low	Resident medicines charts reviewed showed that prescriptions are signed and dated, allergies identified. Two of fourteen medicines charts that were reviewed by the GP within the required three month time frame. Records showed that four of four special authority renewals were not up-to-date. The service provided evidence of having arranged dates later this month when the GP is scheduled to review these medicines charts and the special authority renewals all related to nutritional supplements. These facts were taken into account in mitigation the risks for the residents and the organisation.	<p>i) Not all medicines charts were not reviewed within the required timeframes.</p> <p>ii) Not all special authority renewals (relating to nutritional supplements) had been completed.</p>	<p>i) All medicines chart reviews to be completed within the required timeframes.</p> <p>ii) All special authority renewals to be current.</p> <p>30 days</p>

<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>During review of resident clinical files, the PCCPs were checked to ensure care plans reflect the current needs of residents. Resident files are integrated and include evidence of EPOA where identified. Initial care plans are on file and where residents had acute problems, the files evidenced short-term care plans for the management of such needs. Two of seven residents' PCCPs reviewed reflected the level of care required as identified through the interRAI process.</p>	<p>Resident PCCPs did not consistently reflect the level of care required as identified through the interRAI process.</p>	<p>All PCCPs to show the level care needed by the resident as identified through the interRAI assessment process.</p> <p>90 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA Low</p>	<p>Staff are trained in emergency procedures and trial evacuations are conducted six-monthly, however, the two displayed fire hoses were no longer functioning as serviceable.</p>	<p>The fire hoses did not have evidence of a current serviceability check, had been disconnected and did not indicate that they were no longer serviceable.</p>	<p>Non-functioning firefighting equipment should be fully decommissioned and it should be clear to potential users that these are not serviceable.</p> <p>60 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.

No data to display
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End of the report.