

Oceania Care Company Limited - Middlepark Rest Home & Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Oceania Care Company Limited
Premises audited:	Middlepark 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: 30 August 2018 End date: 31 August 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	49

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
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

Middlepark Rest Home and Village can provide services for up to 61 residents requiring rest home or hospital level of care. There were 49 residents at the facility on the first day of the audit.

This certification audit was conducted to establish compliance with the relevant Health and Disability Services Standards and the facility's contract with the district health board.

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

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

There was an area identified as requiring improvement relating to assessments and care planning not being completed as per the required timeframes.

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 Commissioners' Consumers' Rights; the complaints process; and the Health and Disability Advocacy Service is made available to residents and their families on admission and is posted in prominent areas in the facility. Staff interviews demonstrated an understanding of residents' rights and obligations.

Residents' cultural and spiritual beliefs are identified on admission and there is access to cultural and spiritual support if required.

Information on the complaints process is available to residents and their family. There is a documented complaints management system and a complaints register is maintained. Complaints are investigated and documented, with corrective actions implemented where required. There have been no complaints to external agencies since the last audit.

Staff communicate with residents and family members following any incident and this is recorded in the resident's file.

Residents, family and GP interviews confirmed that the environment is conducive to communication, including identification of any issues, and that staff are respectful of their needs.

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

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement at the facility. Policies are reviewed. Monthly business status reports to the national support office allow for the monitoring of service delivery, and quality and risk performance. Benchmarking reports include clinical indicators, infections, incidents/accidents and complaints. An internal audit programme is implemented. Corrective action plans are documented with evidence of resolution of issues when these are identified. There is an electronic database to record risk in which risks and controls are clearly documented.

The facility is managed by a business and care manager and supported by a clinical manager. The clinical manager is a registered nurse and is responsible for oversight of clinical services. The facility management team is supported by the regional clinical quality manager.

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 one staff member on duty at all times with a current first aid certificate. On-call arrangements for support from senior staff are in place and implemented. Rosters indicated that staff are replaced when on leave.

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 organisation works with the Needs Assessment Coordination Service to ensure access to the facility is efficient with all relevant information available, whenever there is a vacancy.

The residents' needs are assessed on admission by registered nurses. The residents' files provided evidence of documented residents' needs, goals and outcomes that are reviewed on a regular basis. Residents' initial care plans and short term care plans for acute conditions are conducted within the required timeframes.

Nursing care plan evaluations are documented, resident-focused and indicate progress towards meeting residents' desired outcomes. There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and families interviewed reported being informed and involved, and that the care provided is of a high standard.

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

Residents are referred or transferred to other health services as required, with verbal and written handovers carried out.

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

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and needs for feeding assistance or modified equipment met. There is a central kitchen and on site staff that provide the food service. The residents verified satisfaction with meals.

Safe and appropriate environment

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

Bathroom and showering facilities are provided throughout the facility and are easily accessible. 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; cleaning and laundry facilities; safe storage of chemicals and equipment; and correct use of protective equipment and clothing.

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.

Restraint minimisation and safe practice policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use.

There were no residents using restraint or enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour had been provided.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. The service provides an environment which minimises the risk of infection to residents, service providers and visitors.

The infection prevention and control programme is reviewed annually. An infection control nurse is responsible for this programme, including education and surveillance.

New employees are provided with training and orientation in infection control practices and there is ongoing infection control education available for all staff. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided. The results of surveillance are reported through all levels of the organisation, including governance.

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	44	0	0	1	0	0
Criteria	0	92	0	0	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 education programme. Staff interviews confirmed understanding of the Code and their obligations. Evidence that the Code is implemented in their everyday practice included maintaining residents' privacy; providing residents with choices; encouraging independence; involving residents and family 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 family/whānau of choice are provided</p>	FA	<p>The organisation's informed consent policy provides the guidelines to ensure that all residents or their family/EPOA will be informed about the management and care to be provided in order they can make an informed and non-pressured decision about any proposed treatment or procedure.</p>

<p>with the information they need to make informed choices and give informed consent.</p>		<p>It describes what consent involves and how it may be facilitated, obtained, refused and withdrawn. It ensures that staff members adhere to the legal and ethical requirements of informed consent and informed choice for health care services and service provision. The policy includes guidelines for consent for treatment, photographs, specific cares, collection and storage of information, and advance directives.</p> <p>The information pack provided prior to admission includes information regarding informed consent. The BCM discusses informed consent with residents and their families/EPOA during the admission process to ensure understanding.</p> <p>Staff receive training in the informed consent process and 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. Residents' files and interviews confirmed that informed consent is obtained.</p> <p>Advance directives and resuscitation orders are completed for residents when applicable. There is an advanced directives and an end of life policy to ensure that 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 and supporting access to advocacy services. The complaints procedure also includes making residents aware of their right to advocacy when making a complaint.</p> <p>Information regarding the availability of the Nationwide Health and Disability Advocacy Service is provided in the information packs provided to residents and family/EPOA prior to admission to the facility. Additional advocacy services brochures are available on the entrance to the resident dining room.</p> <p>Staff interview confirm that advocacy services can also be accessed on behalf of residents through Age Concern and the Canterbury District Health Board gerontology services.</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 are familiar</p>

		with the advocacy services available.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<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 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 and family outings. The activities programme and the content of care plans includes regular outings in the community.</p> <p>The service is responsive to the needs of young people with disabilities (YPD) ensuring access to activities and resources in the community and facilitating access to family and networks.</p> <p>There is provision for residents who are able, to store, charge and continue to use their mobility scooters in order to mobile freely in the community and surrounding areas.</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>	FA	<p>The organisation's complaints policy outlines the complaints procedure that is in line with the Code and includes the expected timeframes for responding to a complaint. The complaint process and forms are made available as part of the admission pack and complaint forms are available in resident areas of the facility.</p> <p>The BCM is responsible for managing complaints. An up-to-date complaints register is in place that includes: the date the complaint is received; the source of the complaint; a description of the complaint; resolution and the date the complaint is signed off. 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>Staff interviews confirmed that residents and family were encouraged to raise any concerns and provide feedback on services. 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. 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/enduring power of attorney (EPOA) are provided with information on the Code as part of an information pack provided when enquiring about the facility. As part of the admission process, the business care manager (BCM) explains the Code to ensure understanding. The pack also includes information on the complaints process and advocacy service.</p> <p>The Code and associated information are available in brochures displayed at the entry to the facility and available to take away and read in private. Information on the Code is also displayed in posters in English and te reo Māori. Advocacy services can be accessed externally for residents if required.</p> <p>Resident and family interviews confirmed that they are provided with information on their rights and are aware that they can access advocacy services.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The organisation has 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 that doors were shut when cares of a personal nature were being provided. Interviews and observation 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. The policy includes identifying resident needs and responding to expressions of sexuality.</p> <p>Resident files, interviews and satisfaction surveys confirmed that individual cultural, religious and/or social 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 training on abuse and neglect. Interviews confirmed staff are aware of their obligations to report any incidences of suspected abuse. There were 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>	<p>FA</p>	<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 values, and cultural safety at orientation and also as part of the annual education programme. 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 immediate and wider whānau in the delivery of care for any Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family 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 is addressed in care planning. 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. This information informs activities that are tailored to meet identified needs and preferences. Weekly church services are held in different denominations for residents who chose to attend and communion is offered on a weekly basis for catholic residents.</p> <p>Resident interviews and surveys confirmed that the services were responsive to individual residents' 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>	<p>FA</p>	<p>There is a policy to ensure the environment for residents is free from discrimination, coercion; harassment; and financial exploitation. 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 each 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 18 months relating to any form of discrimination, coercion, harassment or exploitation.</p> <p>Staff mandatory training includes professional boundaries. 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 relevant guidelines. The policies align with the Health and Disability Services Standards and ensure safe, current evidence based practice. There are relevant training programmes for all staff. Interviews confirmed that staff have access to external professional programme.</p> <p>The organisation's quality framework includes an internal audit programme to ensure that service delivery complies with documented procedures. Benchmarking occurs across all the Oceania facilities. Results of benchmarking is made available to staff on staff notice boards and through monthly meetings.</p> <p>Resident and family interviews, resident file 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 sets out the process 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.</p> <p>Monthly resident meetings inform residents of facility activities and provide an opportunity to raise and discuss issues/concerns with management. These are advertised on the resident notice board and family/EPOA are invited to attend the meetings. Minutes of the residents' meetings sighted evidenced a range of subjects are discussed such as: upcoming events; activities; food service; and surveys. Residents have access to the minutes from these meetings and are also provided with copies of the planned activities and menu. Residents and staff are also informed of updates and events through the monthly newsletter, which encourages residents and family to call in with comments or suggestions. Interviews confirmed that the BCM and staff were</p>

		<p>approachable and responded promptly to any concerns raised.</p> <p>There is policy that provides guidance and procedures for staff to ensure that residents who do not use English as their first language are offered interpreting services. The policy states that staff have access to a list of interpreting services and family may only interpret with a resident's consent. At the time of the audit there were no residents who required an interpreter. The facility has implemented a process to facilitate effective communication for any resident with a hearing impairment.</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>	<p>FA</p>	<p>Oceania has a documented mission statement, values and goals. These are displayed on the wall in the main hallway and also communicated to residents, staff and family through posters, information in booklets and in staff training.</p> <p>The facility is part of the Oceania group with the executive management team providing support to the facility. Communication between the facility and executive management occurs monthly with the regional clinical and quality manager providing support during the audit. The monthly facility 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 Middlepark with a mission/vision that is linked to the Oceania values.</p> <p>The facility is managed by a BCM supported by a clinical manager (CM). The BCM has a master's degree in public health endorsed in health management and is a registered nurse (RN) with a current practising certificate. The BCM has been in the position for 14 months and has previous experience in the South Island Alliance monitoring team addressing progress on certification non-conformances, as an auditor, nurse manager of an age related care facility, and as a nurse specialist. The clinical care at the facility is overseen by the CM. The CM is a RN who has been in this 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>Middlepark is certified to provide rest home, and hospital level care and currently provides care for up to 61 residents with 49 beds occupied at the time of the audit. Occupancy included 33 residents requiring rest home level care and 16 requiring hospital level care.</p> <p>Middlepark has contracts with the district health board (DHB) for the provision respite and YPD services. There one person, assessed at hospital level care, under the YPD agreement and no</p>

		<p>residents under the respite contract.</p> <p>The facility has 12 owner right to occupy agreement rooms. Eleven of these were occupied at the time of the audit including two residents assessed at hospital level of care.</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>	FA	<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 experienced RNs, 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>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The facility utilises Oceania's documented quality and risk management framework that is available to staff to guide service delivery. Policies are current, 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 at staff meetings and the staff notice board. Policy updates are also provided a part of relevant in-service education. Staff confirmed that they are advised of new and updated policies.</p> <p>The service delivery is monitored through implementation of an internal audit programme and the organisation's reporting systems utilising a number of clinical indicators such as: complaints; incidents and accidents; surveillance of infections; pressure injuries; falls; and medication errors. There is evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data provides evidence that data is being collected and collated, and there is identification of trends and analysis of data. Where required, corrective action plans are developed, implemented, evaluated and closed out. There is communication with all staff of any subsequent changes to procedures and practice through meetings and staff notices.</p> <p>All residents including young people with disabilities and their family/EPOA have the opportunity to have input into services and amenities. 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 and these evidenced</p>

		<p>satisfaction with services provided. This was confirmed by resident and family interviews. A review of survey results for the most recent survey demonstrated an improvement on the previous survey.</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. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly.</p> <p>There is a nominated health and safety representative and interview confirmed a clear understanding of the obligations of the role. Staff interviews confirmed an awareness of the process and responsibility to report hazards. There is evidence of hazard identification forms completed when a hazard is identified and that hazards are addressed and risks minimised. A current hazard register is available that is reviewed and updated annually or when a new hazard is identified.</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. These are reported to the appropriate authority via Oceania and there is evidence of correct and accurate reporting. The BCM reported that there had been one notification of a sentinel event since the last audit. A review of documentation confirmed this.</p> <p>The facility demonstrated a commitment to providing an environment in which all staff are encouraged to recognise and report errors or mistakes. The BCM reported staff are encouraged report hazards and accidents/incidents and this was confirmed in staff interviews. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events. Staff records reviewed demonstrated that staff receive education at orientation on the incident and accident reporting process.</p> <p>Accident/incident reports selected for review evidenced the resident's family had been notified, an assessment conducted and observation completed. Corrective actions arising from incidents were implemented. Information gathered is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Accident/incident reporting forms are 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 documentation in the resident progress notes and notification of the resident's next of kin or</p>

		<p>EPOA where appropriate.</p> <p>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>	FA	<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; and identification verification.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that require them including: RNs, the pharmacists, general practitioner (GP), dietitian, and podiatrist.</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 documented role specific mandatory annual education and training module/schedule. There are systems and processes in place to ensure that all staff complete their required mandatory training modules and competencies. Education session attendance records evidenced that ongoing education is provided.</p> <p>The CM and four RNs have completed interRAI assessments training and competencies. Annual competencies are completed by care staff, for example: hoist use; oxygen use; hand washing; wound management; medication management; and moving and handling. In addition to in-service education, staff completed annual mandatory core training, comprised of four hours for non-clinical staff and eight hours for RNs. Training records reviewed evidenced a minimum of eight hours of relevant training.</p> <p>An appraisal schedule is in place and all staff files reviewed evidenced a current performance appraisal.</p>
Standard 1.2.8: Service Provider	FA	The organisation's staffing policy provides guidance to ensure safe staffing levels within the

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>facility to meet the needs of residents' acuity. Rosters are formulated at least two 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/or the number of residents. There are sufficient RNs and health care assistants (HCA) available to safely maintain the rosters for the provision of care, to accommodate increases in workloads and acuity of residents such as additional hospital level residents.</p> <p>Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy. A review of rosters demonstrated that there is at least one RN on each shift. The BCM and CM are on call after hours, seven days a week.</p> <p>There are 46 staff, including the management team, administration, clinical staff, diversional therapist, health care assistants and household staff. Household staff include cleaners who provide seven day a week cleaning, kitchen staff and activity staff.</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. Staff confirmed 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>	<p>FA</p>	<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 the privacy and confidentiality of resident information. Staff interviews confirmed an 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 staff office. Archived records are securely stored and easily retrievable. Documentation 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 details and reports from other health professionals. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel 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. Records identify the name and designation of the person making the entry.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' entry and the assessment processes are recorded and implemented. When the need for service had been identified, it is planned, coordinated and delivered in a timely and appropriate manner. The organisation works with the local Needs Assessment and Coordination Service (NASC), to ensure access to the facility is appropriate and efficiently managed. Each potential resident who may be admitted to the facility is assessed using the interRAI home care assessment tool in the six months before date of their admission. The needs assessments are completed for rest home and hospital levels of care. The prospective residents and/or their families are encouraged to visit the facility prior to admission.</p> <p>The organisation obtains information from the NASC service and/or the general practitioner (GP) for residents accessing respite care.</p> <p>The residents' admission agreements evidence resident and /or family and facility representative sign off. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care was conducted.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The resident's exit, discharge or transfer is managed in a planned and coordinated manner. Files reviewed evidenced communication between families and other providers, including, exit, discharge or transfer plans as required. At the time of transition, relevant information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the residents' clinical files.</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>FA</p>	<p>There is an electronic medication system implemented, which complies with current legislation requirements and safe practice guidelines. The medication area evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Regular records of temperature checks for the medicine fridge have readings documenting temperatures within the recommended range. The drug register is maintained and evidenced weekly checks and six monthly physical stock takes.</p> <p>All staff authorised to administer medicines have current competencies. A medication round was observed and evidenced the staff members was knowledgeable about the medicine administered and signed off as the dose was administered. Administration records are maintained, as are specimen signatures.</p>

		<p>The residents self-administering medicines at the facility do so according to policy.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for analysis of any medication errors and compliance with this process is verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a seasonal four week cycle menu provided, in line with recognised nutritional guidelines for older people, as verified by a dietitian's assessment of the menu.</p> <p>The service operates with a multi-site approved food control plan applicable to all Oceania Healthcare facilities. The registration expiry date of the food control plan is March 2019. Food temperatures are monitored and recorded as part of the food control plan. The food service staff have undertaken a safe food handling qualification and completed relevant food handling training.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the executive chef and accommodated in the daily meal plan. In interview, the chef confirmed they were aware of the residents' individual dietary needs. The residents' dietary requirements are reviewed on a regular basis. There are current copies of the residents' dietary profiles in the kitchen. Special equipment, to meet residents' nutritional needs, was sighted.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, their individual preferences were met and adequate food and fluids were provided.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p> <p>Evidence of resident satisfaction with meals is verified by residents' and family interviews, sighted satisfaction surveys and residents' meeting minutes.</p> <p>There is one dining room at the facility. A kitchen services review was conducted in February to July 2018 to identify and improve residents' dining experience. The recommendations included two meal settings for lunch and dinner to relieve congestion in the dining room. The residents were seen to be given sufficient time to eat their meal in an unhurried manner and the residents' requiring assistance had this provided. The residents reported satisfaction with the implementation of the two meal settings.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>There is a process to inform residents and their family, in an appropriate manner, of the reasons why the service had been declined and this would be implemented, if required. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.</p> <p>The residents would be declined entry if not within the scope of the service or if a bed was not available, confirmed at management interviews.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found in consultation with the resident and family.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The residents' needs are assessed on admission to establish an initial care plan. The residents have their needs identified through a variety of information sources that include but are not limited to: the NASC interRAI home care assessments; GPs; specialists; other service providers involved with the resident; the resident; family and on-site assessments using a range of assessment tools.</p> <p>The residents' files reviewed evidenced the residents had current interRAI assessments completed by trained interRAI assessors on site, however, not all interRAI assessments were completed within the required timeframes (refer to 1.3.3.3). There was evidence the results of the interRAI assessments were discussed with the residents and where appropriate the family.</p> <p>Residents' assessments are conducted in a safe and appropriate setting including visits from the GP and specialists. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The assessment findings in consultation with the resident and/or family, inform the care plan and describe the required support and interventions. Each resident has a long-term nursing care plan based on assessments carried out using interRAI assessment tool (refer to 1.3.3.3).</p> <p>The residents' care plans, including YPDs, are individualised, integrated and up to date. The care plan interventions reflect the risk assessments and the level of care required. Short-term care plans are developed, when required and signed off by the RN when short-term problems are resolved.</p>

		<p>In interviews staff reported they receive adequate information for continuity of residents' care. The residents have input into their care planning and review.</p> <p>Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written.</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>	FA	<p>The documentation, observations and interviews verified the provision of care provided to residents was consistent with the residents' needs and their desired outcomes. The residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents (refer to 1.3.3.3).The GP documentation and records are current.</p> <p>In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained.</p> <p>In interviews, staff confirmed they are familiar with the current interventions of the residents they were allocated.</p> <p>The facility has appropriate resources and equipment, confirmed at staff interviews and through visual observation. The equipment available complied with best practice guidelines and met the residents' needs.</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>	FA	<p>Residents are assessed on admission to ascertain their social needs and appropriate activity and social requirements, including residents under 65 years of age. The residents' activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matched the skills, likes, dislikes and interests evidenced in the residents' assessment data.</p> <p>In interview, the diversional therapist (DT) confirmed the activities programme meets the needs of the service group and the service has appropriate equipment. The activities programme was evaluated by the BCM in February 2018 to identify if it was meeting residents' needs and as a result of the evaluation number of recommendations have been implemented.</p> <p>Regular exercises and outings are provided for those residents able to participate. The activities programmes include input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations.</p> <p>There were current, individualised activities care plans in residents' files reviewed. The residents' activity needs are evaluated as part of the formal six monthly care plan review. The residents'</p>

		<p>activities attendance records are maintained. Family/whānau and friends are welcome to attend all activities.</p> <p>The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programme. The residents' meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Timeframes in relation to care planning evaluations are documented and implemented. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals are carried out by the RNs and documented on the care plan evaluation form. Reassessments are completed using the interRAI assessments every six months or when changes in resident's health status occurs.</p> <p>There is evidence of resident, family, health care assistants, activities staff and GP input into care plan evaluations. In interviews residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews. The residents' care plans were up to date and reviewed six monthly.</p> <p>The residents' progress notes are entered on each shift and there is evidence residents' care is evaluated and reported on. If any change is noted it is reported to the RN. When resident's progress is different than expected, the RN contacts the GP as required, confirmed at GP interview.</p> <p>Short-term care plans were residents' files when required. A short-term care plan is initiated for short-term concerns, such as infections, wound care, and changes in mobility and the resident's general condition. Short-term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family are included in evaluations and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer</p>	FA	<p>Appropriate processes and supports are in place to provide choices for residents in accessing other health and/or disability services. A multidisciplinary team approach is maintained and progress notes detail relevant processes are implemented.</p> <p>When required, referrals to non-urgent services are completed by the GP or the RN. Copies of referrals were sighted in residents' records reviewed including: radiology; wound care specialist; mental health services for older persons and other health professionals. Referrals are followed up on a regular basis by the GP or the RN. The resident and the family are kept informed of the</p>

choice/needs.		<p>referral process, as verified by documentation and interviews.</p> <p>Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. The GP interview confirmed they are informed of any acute changes in resident's condition and involved in acute referrals to DHB.</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, disposal and collection of waste. The hazard register is available and current.</p> <p>Current material safety data posters are available and accessible to staff in relevant places in the facility. Staff receive training and education in safe and appropriate handling of waste and hazardous substances.</p> <p>Interviews and observations confirmed that there is sufficient personal protective clothing and equipment provided, such as aprons, gloves and masks, which is appropriate to the recognised risks. Protective clothing and equipment was observed to be used correctly in all high-risk areas.</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>	FA	<p>A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with legislation.</p> <p>There is an implemented planned and reactive maintenance schedule. Staff enter maintenance requests in a book and there is evidence that these are responded to and signed of promptly. The facility has an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually.</p> <p>Staff interviews and facility inspection confirmed there is adequate equipment to support care, including care for residents with disabilities.</p> <p>There are quiet areas throughout the facility for residents to use when required. There are paved courtyards; landscaped lawns, and areas with outdoor tables and chairs and shade that are able to be accessed freely by residents and their visitors.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	FA	<p>There are sufficient numbers of accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility. Communal toilets have a system to indicate vacancy and have sufficient disability access. Visitor toilets are conveniently located near</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>communal areas. All rooms have a toilet and a basin and there are 20 rooms including the 12 occupational right agreement (ORA) suites that have a full ensuite toilet/shower facilities.</p> <p>All shower and toilet facilities have: call bells; approved handrails; and sufficient room for other equipment to facilitate ease of mobility and independence. Residents were observed being supported to access communal 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 temperatures 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 if needed. Resident interviews confirmed that there was sufficient space to accommodate furniture; equipment; and staff as required.</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 scooters, 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 meet their relaxation, activity, and dining needs.</p>	FA	<p>The facility has one large main dining room and meals are served in two sittings, to prevent overcrowding of the area. Most residents were observed to have their meals with other residents in communal dining room, however, can choose to have their meals in their room if they wish.</p> <p>A lounge area which can be used for activities is adjacent to the dining room area. There are a number of smaller alcove areas with seating and a view of gardens for residents to sit and read. In addition there are external areas with seating and shade. All areas can be easily accessed by residents and staff. There are sufficient quiet areas for residents and their visitors to access if they wish, this include places where young people with disabilities can find privacy.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>Laundry is undertaken off-site at another facility. This includes laundering of residents' labelled personal clothing. Some items such as delicate woollens are laundered on site and where</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>required personal clothing is ironed. 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. Cleaning duties and procedures are clearly documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores dispensed and mixed chemicals on a trolley when cleaning and is 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>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>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 and interviews and documentation confirmed that fire drills are conducted at least six monthly. There is a monitored fire alarm and sufficient firefighting equipment and signage displayed. There is a nominated fire warden for each shift.</p> <p>There is at least one 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; lighting; an agreement for the supply of an emergency generator; and sufficient food, water, and continence supplies. The facility's emergency plan includes considerations of all levels of resident need including YPD.</p> <p>There are call bells to summon assistance in all resident rooms, including the 12 ORA rooms, toilets and communal areas. Call bells are checked monthly by the maintenance person. 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. These include visitors signing in and out of the building, the facility being locked in the evenings and night time security lighting in place.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All resident rooms and communal areas accessed by residents have safe ventilation and sufficient external windows providing natural light. The facility is heated by a combination of underfloor heating and heat pumps. The environment in all 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. 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 covered smoking area for residents and steps in place to ensure that 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>	<p>FA</p>	<p>The facility's environment minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The infection control nurse (ICN) has access to external specialist advice from Oceania senior management; GPs and DHB infection control specialists when required. A documented job description for the ICN is in place which outlines the role and responsibilities.</p> <p>The infection control programme is reviewed annually. Infection prevention and control is incorporated in facility's meetings. Staff are made aware of new infections through daily handovers on each shift and residents' progress notes.</p> <p>There are processes in place to isolate infectious residents when this required. Hand sanitisers and gels are available throughout the facility for staff, residents and visitors to use.</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>	<p>FA</p>	<p>The ICN is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</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</p>	<p>FA</p>	<p>The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.</p>

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>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>New staff are required to undertake orientation that includes infection prevention and control, evidenced in review of staff files. Staff education on infection prevention and control is conducted by ICN and external specialists. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. The ICN has attended external infection control education in 2017 and 2018.</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 ICN maintains infection logs for residents' infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short-term care plans in place. The GP is informed in timely manner when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p> <p>Monthly surveillance analysis is completed and reported at monthly staff meetings and entered in the clinical indicators on the Oceania intranet. This information is reviewed by the Oceania clinical quality team and reported to the Oceania board on a monthly basis.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RN's, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interviews, the ICN and CM confirmed no outbreak occurred at the facility since last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint minimisation and safe practice policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the CM who demonstrated knowledge of the organisation's policies, procedures and practices relating to restraint and enabler use.</p> <p>On the days of the audit there were no residents using restraints or enablers. The clinical staff interviews confirmed enablers are used voluntarily at a resident's request. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the meeting minutes of the restraint approval group, review of the restraint register and interviews with clinical</p>

		staff and management.
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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 1.3.3.3</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</p> <p>Moderate</p>	<p>Home care assessments using the interRAI home care assessment tool are completed prior to the residents' admission to the facility. However, two of seven residents' files did not have interRAI assessments completed within the 21 day timeframe post admission.</p> <p>Review of the residents' clinical files evidenced the initial care plans are completed within the required timeframe. However, four of seven long-term care plans were not completed within 21 days of admission.</p>	<p>The interRAI assessments and the long-term care plans are not always completed within the required 21 days post residents' admissions to the facility.</p>	<p>Provide evidence the timeframes relating to interRAI assessments and long-term care plans are adhered to.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.