

# Oceania Care Company Limited - Amberwood Rest Home

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Amberwood Rest Home

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 18 September 2018 End date: 19 September 2018

**Proposed changes to current services (if any):** The change of 18 rest home rooms (1 wing) to dual purpose rooms. There will be no change in the total number of beds (70) comprising of 69 dual purpose beds and 1 rest home bed.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 60



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

## General overview of the audit

Amberwood Rest Home provides rest home and hospital level of care for up to 70 residents. There were 60 residents residing at the facility on audit days.

This surveillance audit was conducted against a sub set of the Health and Disability Service Standards and the service contract with the district health board. The audit processes included the review of policies, procedures, residents and staff files, and observations and interviews with residents, family, management, staff and a general practitioner.

A partial provisional audit was also undertaken to establish the level of preparedness of the provider to provide a reconfigured service. The proposed change consists of 18 rest home rooms to dual purpose rooms. There will be no change in the total number of beds within the facility. The completion of the partial provisional audit confirmed the provider's preparedness to provide the reconfigured service.

The previous certification audit identified two areas requiring improvement relating to medication management and food service and these have both been met. This surveillance audit identified areas requiring improvement relating to the complaints management and timeframes relating to care services.

## Consumer rights

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| <p>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.</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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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service are all accessible and available to residents and their family.

Residents are informed and have choices relating to the care they receive. Residents and family members confirmed their rights are being met, staff are respectful of their needs and communication is appropriate.

Policy and procedures relating to the complaints management process comply with the Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

## Organisational management

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| <p>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.</p> |  | <p>Standards applicable to this service fully attained.</p> |
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Amberwood Rest Home is part of the Oceania Healthcare Limited (Oceania). Oceania mission statement and values of the organisation are documented and communicated to all concerned. Oceania has a documented quality and risk management

system that supports the provision of clinical care and support. The quality and risk performance is monitored by the management team and communicated monthly to Oceania support office. Policies and procedures are reviewed at Oceania support office and these are current.

The facility is managed by an experienced and suitably qualified business and care manager who is a registered nurse with aged care experience. The clinical manager is responsible for the oversight of the clinical services in the facility.

Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators. These are used to provide comparisons with other Oceania residential care facilities and inform staff.

There are human resource policies implemented around: recruitment; selection; orientation; staff training and development and support good employment practice. Orientation programme and an in-service education programme is provided and completed by staff.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Staff are allocated to support residents' individual needs.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The residents' person centred care plans record interventions which are detailed to address the residents' care needs. Care plans are evaluated when a resident's condition alters or six monthly. The short-term care plans are developed for short-term problems and evaluated in a timely manner.

Planned activities are appropriate to the needs, age and culture of the residents. Residents reported activities are enjoyable and meaningful to them.

The medicine management system is documented and implemented. Staff medication competencies are maintained. There was one resident who self-administers medications on audit days, competencies for this and storage was appropriate.

Food services meet food safety guidelines and legislation. The individual food, fluids and nutritional needs of the residents are met. The kitchen manager is qualified and experienced and ensures the kitchen is clean, organised and meets all food safety standards. Residents and family interviewed verified satisfaction with meals.

The service has adequate facilities and resources in providing activities, medicines management and food services to facilitate an increase of dual purpose beds.

## Safe and appropriate environment

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| 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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The facility has a current building warrant of fitness. There has been no alteration to the building since the last audit.

Preventative maintenance and compliance monitoring ensures that the physical environment meets the needs of the residents and health and safety requirements. Electrical and medical equipment, furniture and fittings are maintained in safe working order.

All residents' bedrooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Lounges, dining areas and alcoves are available for residents and visitors use. External areas are available for use and these areas are maintained to ensure safety.

The cleaning and laundry services are monitored. Personal protective equipment is readily available for staff. Appropriate training, information, and equipment for responding to emergencies are provided. An appropriate call bell system is available to allow residents to access help when needed in a timely manner. There is an approved evacuation plan and fire drills are conducted six monthly. Emergency management plans and equipment are in place.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |
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The restraint minimisation and safe practice policies and procedures record the safe use of restraints and enablers and comply with this standard. There were no residents using restraints or enablers at the facility during the on-site audit. Staff interviewed confirmed their understanding of restraint and enabler use and receive ongoing restraint education.

## Infection prevention and control

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

The infection control surveillance activities are appropriate to the size and scope of the services provided. Infection control management systems are in place to minimise the risk of infection to residents, visitors and staff. Infection data is collated monthly, analysed and reported to Oceania Healthcare Limited support office, management and staff. Results of the surveillance are acted upon, evaluated and reported. There has been an outbreak of norovirus and this was managed effectively.

The infection prevention and control programme and surveillance processes are adequate to facilitate an increase of dual purpose beds.

## Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 23                  | 0  | 0                                    | 2  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 57                  | 0  | 0                                    | 2  | 0                                      | 0  |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome  | Attainment Rating      | Audit Evidence  |
|--|------------------------|---|
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>PA<br/>Moderate</p> | <p>The organisation's complaints policy and procedure are in line with the Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and include periods for responding to a complaint. The complaint forms are available at the entrance to the facility. The residents and their family are informed about the complaints process on admission to the facility. Residents and family members interviewed stated that they would feel comfortable to make a complaint.</p> <p>A complaints register is in place and includes: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. A review of complaints for 2018 was conducted and the documented processes require improvement.</p> <p>There is one investigation by the Health and Disability Commissioner which remains open. The facility has provided the information requested and is awaiting the outcome/closure of the investigation.</p> <p>There was an external complaint forwarded to the DHB in July 2018. Related records were reviewed. This complaint has been investigated with an area for improvement identified by the facility to ensure family members are always notified of any changes in care condition and of visits by general practitioner (GP). There were no other external complaints as confirmed by management interviews.</p> |

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| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>Oceania Healthcare Limited policies and procedures guide staff on the process of open disclosure of information. Management and staff notify family/enduring power of attorney of accidents/incidents that occur or when a resident's condition alters. Family contact is recorded in the residents' clinical files. Interviews with family members confirmed they are kept informed.</p> <p>Interpreter services are available from the district health board (DHB) when this is required. The residents and family receive an information pack on admission and this contains all required information regarding the services provided at the facility. Residents or family sign an admission agreement on entry to the service.</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>Amberwood Rest Home is part of Oceania Healthcare Limited (Oceania). Oceania has the organisation's vision, mission, and values displayed at the facility. The BCM responsible for the overall management of the facility and has been in this role for approximately two years. The BCM is supported in their role by the Oceania support office staff. The Oceania regional clinical and quality manager provided support during this on- site audit.</p> <p>The CM is a registered nurse (RN) who has been in this position since March 2018. Both managers undertake education and training relevant to their roles, exceeding eight hours annually.</p> <p>The facility can provide care for up to 70 residents at rest home and hospital levels of care. Occupancy on the first day of audit was 60 residents, this included 37 residents at hospital level and 23 residents at rest home level care.</p> <p>Oceania applied to HealthCERT for approval to reconfigure services from 51 dual purpose rooms to 69, by the change of 18 rest home rooms to dual purpose rooms. The 18 rest home rooms are located in one wing of the facility. The wing also includes one room which will remain allocated as rest home level care only. As a result of this reconfiguration there will be no change in the total number of beds at the facility. The observations, interviews and review of data confirmed management are taking steps to ensure the reconfiguration of services does not impact on the services capacity to meet the requirements of the Health and Disability Services Standards and the contract with the DHB.</p> <p>Additional contracts provided at the facility are: long-term residential services contract for people under 65 years with chronic health conditions (three hospital level care residents with physical disabilities); and residential respite services contract (one resident under this contract at rest home level of care).</p> |
| <p>Standard 1.2.2: Service Management</p>   | <p>FA</p> | <p>In the absence of the BCM, the CM is delegated to perform this role, with support from the Oceania regional operations manager and the clinical and quality manager. During the CM's temporary absence,</p>  |

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| <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>the replacement is arranged by the Oceania support office staff.</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>Amberwood Rest Home uses the Oceania quality and risk management framework that is documented to guide practice. The BCM reports to the Oceania support office and management reports are completed monthly. There is a documented operational and business brief for the facility.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. The policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. New and revised policies are communicated to staff to ensure staff are kept informed and updated. Documents are maintained of staff signatures that they have read and understood the new/revised policies.</p> <p>A range of quality related activities are conducted. The service delivery is monitored through: complaints; review of incidents and accidents; surveillance of infections; clinical indicators; and implementation of an internal audit programme. The quality data evidenced: collection; collation; and identification of trends and analysis. The quality data reports are communicated to Oceania support office. Benchmarking reports are produced by the Oceania support office and provide comparisons with other Oceania residential care facilities. This data is shared with all Oceania facilities, staff and management.</p> <p>Facility meetings and meeting minutes provided evidence of communication with management and staff around all aspects of quality improvement and risk management. Interviews with staff confirmed they are informed about quality activities. There are planned resident and family meetings that keep residents informed of any changes and provide opportunity for discussions.</p> <p>There is a six monthly family and resident satisfaction survey. The survey was last conducted in August 2018 and indicated areas requiring improvement relating to environment cleanliness and laundry. These areas are in the process of documenting corrective action plans.</p> <p>Oceania is a member of Site Safe New Zealand Limited with membership expiring in May 2019. The Oceania health and safety annual plan records actions required to be carried out and there is evidence this is being implemented. The progress of this plan is reviewed by the BCM and at the health and safety monthly meetings. Health and safety objectives are recorded. Risk/hazard registers are current, documented and reviewed and include risk relating to clinical, human resource management and</p> |

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|   |    | environmental risks.   |
| <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> | FA | <p>The management team are aware of the situations/events in which the service would need to report and notify statutory authorities of the events occurring. Policy and procedures comply with essential notification reporting for example: health and safety; human resources and infection control. Authorities were notified when the new CM was appointment to their role.</p> <p>Staff interviews confirmed staff recognise and report errors or mistakes. Staff receive education at orientation and as part of the ongoing mandatory training programme on the incident and accident reporting processes. Incident/accident reports documented had a corresponding note in the progress notes to inform staff of the incident/accidents. Information gathered around incidents/accidents is analysed with evidence of improvements put in place. There was evidence of open disclosure for each recorded event.</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>Written policies and procedures in relation to human resource management are documented and implemented. The staff files reviewed included all required employment documentation including but not limited to: appointment documentation; signed contracts; orientation programme; job descriptions; police checks; reference checks and interviews. There is staff appraisal process in place and this was up to date at the time of audit.</p> <p>The RNs and the CM have current annual practising certificates, along with other health practitioners involved with the service.</p> <p>All new staff complete an orientation programme that includes the essential components of the services provided, confirmed at staff interviews. There is a buddy programme for orientating new staff. Clinical staff are required to complete clinical competencies prior to delivering care to residents.</p> <p>Specific annual mandatory study days for RNs, health care assistants (HCAs) and non-clinical staff are organised and available for all staff to complete. The staff attendances are documented with all staff undergoing this mandatory training. The education and training hours were at least eight hours a year for each staff member. Staff interviews confirmed the mandatory study days are informative and valuable.</p> <p>The interRAI training and competency has been achieved by six RNs. In addition there is one RN in training and one RN is booked to commence training in October 2018.</p> |

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| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>    | <p>FA</p> | <p>The interview with the BCM confirmed the staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents.</p> <p>The CM works Monday to Friday on mornings and support RNs in service provision. The current and past rosters sighted and evidenced there is RN cover 24 hours a day, seven days a week. Management confirmed additional staff are rostered if resident numbers or acuity increases. The BCM and CM are on call after hours and weekends and staff are aware of this. The rosters evidence the RNs have allocation of one day a week to focus on quality activities such as wounds, falls pressure injury. This was confirmed at RN and CM interviews.</p> <p>Proposed roster templates for the reconfiguration application for increased dual purpose beds at the facility were sighted. Interview with the BCM confirmed staff rostering is according to the Oceania rostering methodology policy taking the layout of the facility into account.</p> <p>All staff that are required to have first aid certificates hold current certificates. Care staff reported there are adequate staff available and that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care.</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>The medicine management system is documented and implemented and complies with legislation, protocols and guidelines. The service uses pharmacy pre-packaged medicine that is checked by the RN on delivery. A computer based medication system is used.</p> <p>Weekly checks and six-monthly drugs stocktakes are conducted. The previous requirement for weekly drug checks to be completed has been closed out. The drugs registers were correct and current. The medication fridge temperatures are monitored. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are stored appropriately.</p> <p>The staff administering medication complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled.</p> <p>There was one resident who self-administered medications on audit days. The GP completes three-monthly competency reviews and the resident has secure storage for their medicines. The RNs check with the resident for administration of medicines at every shift. Policies and procedures are in place to ensure safe storage and compliance in relation to self-administration of medications.</p> <p>The service included a nurses' station in close proximity to the rooms converted into dual purpose and there is facilitation for safe storage of drugs. The facility will be able to provide safe medicines management services to the area with converted dual purpose beds.</p> |

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| <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>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with a multi-site approved food control plan applicable to all Oceania facilities. The registration expiry date of the food control plan is March 2019. The kitchen staff have current food handling certificates. Diets are modified as required and the kitchen manager confirmed awareness of the dietary needs of residents. The kitchen manager is also a recognised food safety assessor.</p> <p>Meals are prepared on site and served in the respective dining rooms. The seasonal menu has been reviewed by a dietitian.</p> <p>Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager and kitchen hands have completed relevant food handling training.</p> <p>The residents' dietary profiles are developed on admission and identify the residents' dietary requirements and preferences. The dietary profiles are communicated to kitchen staff on a resident's admission to the facility, when a resident's dietary needs change and when dietary profiles are reviewed six monthly. Supplements are provided to residents with identified weight loss issues. Residents' weights are monitored monthly or more frequently if required.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. All decanted food had records of use by dates recorded on the containers and no expired items were sighted. The previous requirement for improvement relating to pre-prepared food, opened food containers or de-canted food to be identified and dated has been closed out.</p> <p>The lunchtime meals were observed. Resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance to residents as needed.</p> <p>The residents and family interviewed indicated satisfaction with the food service.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs</p>  | <p>FA</p> | <p>The person centred care plans and the short-term care plans are developed by the RNs. The care plan interventions in both the person centred care plans and the short-term care plans are detailed to address the desired goals/outcomes of the residents (refer to 1.3.3.3). Changes in a resident's condition are reported to the GP as confirmed at GP interview.</p> <p>Monitoring forms are in use, such as: weights; vital signs; wounds and challenging behaviour. The</p>   |

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| and desired outcomes.   |    | <p>wound assessments and wound management plans are in place for residents who require them (refer to 1.3.3.3). There is access to specialist services when needed. Referrals are initiated by the GP or by the RNs.</p> <p>Clinical supplies are available and staff confirmed they have access to medical supplies and equipment. Residents and family members interviewed reported satisfaction with the care and support they are receiving.</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>The residents' activities programme is developed by the activities coordinator (AC) who is in the process of completing the diversional therapist training. The activities programme was implemented seven days a week with special opportunities for more activities for those residents who are under 65. The service has four assistant activity coordinators and activities are specific to residents' preferences and needs.</p> <p>The residents' activities assessments are conducted by the AC within the three weeks of the residents' admission to the facility. Residents' interests are gathered during an interview with the resident and their family. The activity care plan is part of the person centred care plan and reflects the residents' preferred activities. There was evidence the activities staff are part of the evaluation process.</p> <p>The residents (including young people with disabilities) and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging in a variety of activities and outings.</p> <p>Resident meetings are conducted monthly. Past minutes of residents' meetings are displayed on notice board for resident and family information. The facility is equipped to facilitate activities for more residents at hospital level of care.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | FA | <p>The person centred and the short-term care plans are evaluated in a comprehensive and timely manner. The evaluations include the residents' degrees of achievement towards meeting the desired goals/outcomes. Residents' responses to the treatment regime is documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved (refer to 1.3.3.3).</p> <p>The short-term care plans are developed when needed and record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved.</p>  |
| Standard 1.4.1: Management Of   | FA | Oceania has documented processes for handling waste and hazardous substances and these are   |

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| <p>Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> |           | <p>implemented at the facility. These processes are in accord with infection control principles and comply with local body requirements. A hazardous substance register is current and maintained. Chemicals are accessed through a closed chemical dispensing system and secure storage is provided. Material safety data sheets are available in the facility.</p> <p>There has been a change of an external supplier of hazardous substances and cleaning products and staff have received training in the handling of the new chemicals, confirmed at staff interviews and sighted in the staff education records reviewed. Personal protective equipment is provided and was observed to be used by staff.</p>  |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>   | <p>FA</p> | <p>A current building warrant of fitness is displayed.</p> <p>There is a preventative and reactive maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. A maintenance person is employed and there is evidence that any maintenance issues are addressed in a timely manner. The testing and tagging of equipment and calibration of bio medical equipment is current.</p> <p>The external areas available are safely maintained and appropriate to the resident group and setting. Residents have access to outdoor seating and shade provided in external areas.</p> <p>Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use the equipment. There is sufficient space for the use and storage of mobility aids. Interviews with management confirmed additional equipment and supplies will be sourced, if required for the planned reconfiguration. Facility specifications do not require any additional alterations or additions for the planned reconfiguration of services to commence.</p> <p>The facility has completed a satellite servery refurbishment in both the rest home and hospital dining rooms. Review of documentation and observation showed there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose and minimise harm to residents, staff and visitors. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>Residents/family satisfaction surveys and interviews confirmed general satisfaction with the environment.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>  | <p>FA</p> | <p>Bedrooms throughout the facility have either: own toilet ensuites; shared toilet ensuites; shared full ensuites; and the residents who reside in rooms with no ensuites use communal toilet and bathroom facilities. There are adequate number of accessible communal showers, toilets and hand basins for residents. Toilets and showers are of an appropriate design and a system that indicates if it they are</p>   |

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| <p>facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>   |    | <p>vacant or occupied. Staff and visitors' toilets are provided. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned.</p> <p>Hot water temperatures are monitored monthly and are maintained at a safe temperature.</p> <p>Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</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>All residents' bedrooms in use provide single accommodation. There is one double room that is presently used for activities. This double room is equipped with the required provisions, to be able to be used again when there is a request for a shared room. All rooms are personalised to varying degrees. Bedrooms are large enough to provide personal space for residents, and allow staff and equipment to move around safely, including the bedrooms identified for the planned reconfiguration of services. There is one bedroom that is of smaller area that has been allocated to a rest home level care resident only. The 18 rest home residents' bedrooms for reconfiguration to dual purpose use are fit for this purpose.</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>Adequate access is provided to the lounges and dining areas. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.</p>  |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>                     | FA | <p>Cleaning policy and procedures are available and implemented. The facility was observed to be clean and tidy on audit days.</p> <p>The laundry is located below Amberwood's care facility and provides laundry services for other Oceania facilities.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner described the cleaning processes.</p> <p>Observations provided evidence that safe and secure storage areas for cleaning trolley and chemicals are available and staff have appropriate and adequate access to these areas. Sluice rooms are available</p>  |

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|  |    | for the disposal of soiled water/waste. Hand washing facilities are available and hygiene standards are maintained in storage areas.   |
| <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>  | FA | <p>Documented systems are in place for essential, emergency and security services.</p> <p>A New Zealand Fire Service letter approving the fire evacuation scheme dated 28 June 2010 was sighted. The facility does not require building alterations for the planned reconfiguration to occur and no changes to the current fire evacuation plan is required. Trial evacuations are held six monthly.</p> <p>Information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply, blankets and cell phones.</p> <p>There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident groups and setting. Call bells are accessible and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner.</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>Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and families confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> <p>An outside area is available for both residents and staff who smoke.</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</p>  | FA | <p>Amberwood implements the Oceania group infection control programme. The content and detail of their infection prevention and control programme is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the infection control nurse.</p> <p>The infection control committee has representatives in each area of service provision who meet monthly. Infection control matters are discussed at the facility monthly in the clinical and quality meetings with all staff. Minutes are available for staff. The infection control programme is reviewed annually at organisational level. 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 all hospital level residents.</p>  |

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| scope of the service.  |    |   |
| <p><b>Standard 3.5: Surveillance</b></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 infection control surveillance policy identifies the requirements around the surveillance of infections and the type of surveillance to be undertaken. Infection logs are maintained. Infection events and collated monthly by a registered nurse. The collated infection control information is communicated as clinical indicators to the Oceania support office and to management and staff. The clinical indicators are reviewed by the Oceania clinical quality team and reported to the Oceania board.</p> <p>Residents' files evidenced the residents diagnosed with an infection had short-term care plans in place. The GP interview confirmed any suspected infection is reported to the GP in a timely manner.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>At interview, the clinical manager confirmed there had been an outbreak of norovirus during August 2018 and records confirmed that this was managed effectively. The outbreak was reported to the public health unit and HealthCERT.</p> |
| <p><b>Standard 2.1.1: Restraint minimisation</b></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>The restraint coordinator is the CM. A signed position description was sighted. There were no residents using restraints or enablers on audit days. The service has a restraint register, should they need to implement restraints or enablers.</p> <p>The national restraint authority group meeting review of restraint practices annually including: if restraint is used; the type of restraints used; extent of restraint use and trends; progress in reducing restraint use nationally; adverse outcomes from restraint use; and staff compliance of the restraint standard. Nationally the data shows there has been significant reduction in restraint use.</p> <p>Staff receive restraint education via the Oceania study days and RN study days.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | <p>PA</p> <p>Moderate</p> | <p>The Oceania complaints management system is documented and includes the requirements to maintain a complaints register and to report complaints to Oceania support office on a monthly basis.</p> <p>Review of six complaints, relating to care and treatment in the complaints register was conducted, and included the July 2018 DHB complaint.</p> <p>There was recorded evidence of closed out complaints, however, no records were available of the complaints being resolved to the complainants' satisfaction.</p> <p>Two complaints showed they were not acknowledged in writing within 5 working days of receipt of the complaints and the complainants were not informed of their right to forward their complaint to the Health &amp; Disability Commissioner, as per Right 10 of the Code.</p> <p>One complaint become 'protracted', however there was no evidence the complainant received regular updates on a</p> | <p>The complaints register does not record all complaints submitted and the processes relating to complaints management do not consistently comply with the Right 10 of the Code.</p> | <p>Provide evidence all complaints are recorded on the complaints register and complaints management complies with the Right 10 of the Code.</p> <p>90 days</p> |

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|  |                           | <p>monthly basis.</p> <p>Complaints were not consistently recorded on the Oceania complaint form. There was evidence of verbal complaints received by the clinical manger (CM) that were not recorded on the complaint form and not communicated to the business and care manager (BCM) in a timely manner. The BCM received this information in an email after asking for this information to be presented.</p> <p>Review of data relating to a complaint evidenced this was not recorded on the complaints register.</p>   |   |   |
| <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>During review of resident clinical folders and tracer methodology of a resident receiving hospital level care, it was found that each stage of service provision for this resident, did not occur within the timeframes that safely meet their needs.</p> <p>A pressure injury was not identified on admission. Daily care of this resident also did not identify the residents' need for pressure care during administration of activities of daily living/personal care and hygiene. This resulted in the resident having four gangrenous pressure injuries.</p> <p>Review of the wound care folder showed that there is specialist input into the care of these pressure injuries and three of the four injuries show signs of improving. The service CM took steps to inform staff on how to recognise pressure injuries (a poster) and sent a memo to staff as a reminder, however, there was no evidence that re-training occurred.</p> | <p>Not all residents have their assessment, planning, provision, evaluation and review needs, consistently met.</p> | <p>To consistently meet the individual assessment, planning, provision, evaluation, review needs of all residents.</p> <p>90 days</p> |

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

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

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

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

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End of the report.