

Oceania Care Company Limited - Meadowbank Village - Care Centre

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: Meadowbank Village - Care Centre

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

Dates of audit: Start date: 30 October 2018 End date: 31 October 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: 19

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

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

General overview of the audit

Meadowbank Village Care Centre is part of Oceania Healthcare Limited. The service provides residential care for up to 30 residents with the capacity for all beds to be made available under occupational right agreements. Occupancy at the time of the on-site audit was 19 residents.

The audit was conducted against the Health and Disability Sector Standards and the contractual agreement 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 general practitioner.

Staffing is stable with minimal turnover. Staff hours are increased if required to meet the needs of residents. Residents and family interviewed had positive feedback on the care provided.

There are improvements required in relation to care planning and the environment.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service are accessible at the facility. This information is also brought to the attention of residents and their families on admission to the facility. Residents confirmed their rights are being met, staff are respectful of their needs and communication is appropriate.

The service has a documented complaints management system and a complaints register is maintained.

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 and is responsible for the service provided at Meadowbank Village Care Centre.

There have been no changes to staffing structure or systems since the partial provisional audit. The business and care manager and the clinical manager provide operational and clinical oversight of the service. The facility management team are supported by the Oceania regional operations manager and clinical quality manager.

The service has a planned, documented quality and risk management system that supports the business management and provision of clinical care. Quality and risk performance is reported through meetings at the facility and is monitored by the organisation's management team through the business status reports and regional operations manager reports. The quality

programme includes a risk management system, including an internal audit programme, education and training, meetings, incident and accident monitoring, health and safety management, complaints management, and management of restraint and infection control. The facility uses the company-wide electronic system to record and monitor key quality indicators and organisational performance.

Human resource policies and procedures guide practice. The validation of current annual practising certificates for personnel who require them to practise is occurring. In-service education is provided for staff, including compulsory training around clinical service delivery. Review of staff records provided evidence that human resource processes are being followed.

Staffing levels are adequate across the service. Registered nurses are on duty 24 hours, 7 days per week and are supported by appropriate levels of care and allied health staff. There are at least two staff with current first aid certification on duty at all times.

The service uses an electronic consumer information management system which is protected from unauthorised access.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		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' needs are assessed on admission by registered nurses and the initial care plans are developed. The residents' files provided evidence of documented residents' needs, goals and outcomes that are reviewed on a regular basis. Short-term care plans for acute conditions are implemented when required. Nursing care plan evaluations are documented, resident-focused and

indicate progress towards meeting residents' desired outcomes. The residents and families interviewed reported being informed and involved.

Planned activities are appropriate to the residents assessed needs and abilities. Residents expressed satisfaction with the activities programme in place. The activities programme includes a wide range of activities and involvement with wider community. 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 appropriate verbal and written handovers.

There is a medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. There is a central kitchen and on-site staff that provide the food service. Resident interviews 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.

Some standards applicable to this service partially attained and of low risk.

The new facility has a current certificate of public use and an approved fire evacuation plan. The building is purpose built for this environment. All residents' care suites provide single accommodation and are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

The preventative maintenance programme includes equipment and electrical checks. There are policies and procedures for waste management, environmental, cleaning, laundry, emergency and security management. Visual inspection provided evidence of sluice facilities in all areas and safe storage of chemicals and equipment. There is availability of protective equipment and clothing.

An appropriate call bell system is available and security systems are in place.

The laundry service is contracted out. Cleaning services are provided seven days a week.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

The 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 was one resident using restraint and no residents requesting the use of enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour has 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 the requirements of the standard. The service provides an environment which minimises the risk of infection to residents, staff and visitors. Infection control education is provided to staff as part of their orientation and as part of the ongoing in-service education programme.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. 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	48	0	1	1	0	0
Criteria	0	99	0	1	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	<p>Staff receive training in the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights' (the Code) at least annually as confirmed in records sighted. Care staff were observed interacting with residents in a respectful and supportive manner.</p> <p>Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, providing choices, encouraging independence and ensuring residents can continue to practise their own personal values and beliefs.</p> <p>Residents and family members interviewed verified that services are provided with dignity and respect, privacy is maintained, and individual needs and rights are upheld.</p> <p>Education relating to the Code, including the complaints process, is provided by Health and Disability Advocacy services and as part of grow, educate and motivate study days.</p>
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make	FA	<p>There is an informed consent policy and procedure to guide staff in relation to gathering of informed consent. This included guidelines for consent for resuscitation and advance directives. The GPs sign to state the competence of the resident and the resuscitation status selected.</p> <p>Staff ensure that all residents are aware of treatment and interventions planned for them, and the</p>

informed choices and give informed consent.		<p>resident and/or significant others/EPOA are included in the planning of that care. Residents' files identified that informed consent is obtained. Staff confirmed their understanding of informed consent processes.</p> <p>The information pack for new residents and their families/whānau includes information regarding informed consent. The BCM and CM discuss informed consent processes with residents and their families/whānau during the admission process. Staff confirmed their understanding of informed consent processes.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>There are policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates when needed. The role of advocacy services is included in training on the Code which is provided annually to staff.</p> <p>Information on advocacy services through the Health and Disability Commissioner's Office is provided to residents and families. Information on advocacy services is available at the entrance to the service along with nationwide advocate details. The admission pack reviewed included advocacy, complaints and Code of Rights information as well as advanced care planning.</p> <p>Discussions with families and residents identified that the service provides opportunities for the family or EPOA to be involved in decisions. Resident files included information on residents' family/whānau and chosen social networks. Residents and family interviewed confirmed that advocacy support is available to them if required, including information on how to access a Health and Disability advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy and residents may have visitors of their choice at any time. The facility is secured in the evenings. Visitors can access the facility after doors are locked using the bell at the entrance. Families confirmed they could visit at any time and are always made to feel welcome. Residents, including YPD, are encouraged to be involved in community activities and to maintain networks with family and friends. Residents' files reviewed and handover demonstrated that progress notes and the content of care plans include regular outings and appointments.</p>
<p>Standard 1.1.13: Complaints Management The right of the consumer to make a</p>	FA	<p>The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. The BCM is responsible for managing complaints. Complaint forms are available at the entrance of the facility and provided in facility information</p>

<p>complaint is understood, respected, and upheld.</p>		<p>packs.</p> <p>There were 3 complaints for 2018. 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. Staff, residents and family confirmed they knew the complaints process.</p> <p>Residents and family stated that complaints are dealt with as soon as they are identified. Residents and family members were able to describe their rights and 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>	FA	<p>The business and care manager (BCM) and the clinical manager (CM) discuss the Code with residents and their family during the admission process. Discussion relating to the Code is also included on the agenda and discussed at the residents' meetings.</p> <p>Resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. The posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English.</p> <p>Residents and family interviewed received copies of the Oceania handbook which includes information on residents' rights.</p> <p>Residents interviewed confirmed they had access to an advocate when needed.</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>	FA	<p>The service has a philosophy that promotes dignity, respect and quality of life. The service ensures that each resident has the right to privacy and dignity. Conversations of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings. Healthcare assistants (HCA) report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families confirmed that residents' privacy is respected.</p> <p>Resident files reviewed, including file the young person with a disability (YPD), confirmed that cultural and/or spiritual values and individual preferences are identified.</p>

		<p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate manner. Policy and guidelines provide strategies for the management of inappropriate behaviour.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe how to recognise this. There are no documented incidents of abuse or neglect in the business status reports or on the incident/accident forms reviewed in residents' files. Residents, staff, families and the general practitioner confirmed that there was no evidence of abuse or neglect. Staff interviewed were aware of the need to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service implements cultural safety policies and procedures to eliminate cultural barriers. There are processes in place to ensure residents who identify as Māori have their needs met.</p> <p>The rights of the residents/whānau to practise their own beliefs are acknowledged in the Māori health plan, which forms part of the quality plan. The Māori health plan includes the principals of the Treaty of Waitangi: partnership, participation and protection and the holistic view of Māori health is incorporated into the service delivery through care planning. Residents have access to Māori support and advocacy services if required.</p> <p>Cultural training for staff is provided as part of the annual training programme. Health care assistants confirmed an understanding of cultural safety in relation to care. The leisure/activities coordinator completes cultural assessments on admission and reviews activity plans six monthly.</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>	FA	<p>Residents and families confirmed they are involved in the assessment and the care planning processes. Residents' files reviewed demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whānau contact details. Residents interviewed confirmed their spiritual needs are met.</p> <p>Documentation reviewed provided evidence that appropriate culturally safe practices are implemented and maintained. Health care assistants confirmed an understanding of cultural safety in relation to care. The service has residents from other cultures and they confirmed during interview that their cultural needs are met.</p>

<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility implements the Oceania Healthcare Limited (Oceania) policies and procedures to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Job descriptions include the responsibilities of position including ethical issues relevant to the role.</p> <p>Staff complete orientation and induction which includes recognition of discrimination, abuse and neglect. Staff training includes discussion of the staff code of conduct and prevention of inappropriate care.</p> <p>Out of the 3 complaints recorded in the complaints register for 2018, none related to discrimination, abuse or neglect.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	FA	<p>Policies include current good practice and are aligned with legislative requirements and guidelines. Staff interviews described practices based on policies and procedures. Staff have access to information on good practice provided by governing bodies and specialists in the region.</p> <p>There is a staff training programme. Training is provided by specialist educators as part of the in-service education programme. Registered nurses (RN) attend compulsory education at the district health board (DHB) and complete the professional development and recognition programme through the DHB.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident and incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney (EPOA) of any accident/incident that occurs. An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. These procedures guide staff on the process to ensure full and frank open disclosure was available.</p> <p>Clinical files reviewed evidenced timely and open communication with residents and their family members. Communication with family members is recorded in progress notes. There is evidence of communication with the general practitioners (GP). Interviews with resident, including YPD, confirmed they are satisfied with how the staff communicate.</p> <p>A facility newsletter is formulated monthly. Families and residents are informed of the range of services provided. Residents sign an admission agreement on entry to service. This provides clear information around what is paid for by the service and by the resident. Interviews with residents and families confirmed their satisfaction with the services provided at this facility.</p>

		<p>The BCM advised that interpreter services can be accessed from Auckland District Health Board when required. There were no residents at the facility needing interpreter services during the on-site audit.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Meadowbank Village Care Centre is part of Oceania Healthcare Limited with the executive management team providing support to the service. The organisation has values, goals and a mission statement in place. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff orientation and training.</p> <p>The BCM has 12 years' experience in aged care in both operational and clinical roles. The BCM is supported by the regional clinical quality manager who was present during the on-site audit. The CM is responsible for overseeing clinical matters. The CM has 6 years' experience as a RN in health of older people in New Zealand and has been in this role for one year. Job descriptions and interviews with the BCM and CM confirmed their responsibility and reporting line for their roles.</p> <p>A monthly business status report is provided to the executive management team. Reports include quality and risk management issues, occupancy numbers, human resource issues, quality improvements, internal audit outcomes and clinical indicators.</p> <p>Meadowbank Village Care Centre is currently certified to provide aged related residential care rest home and hospital level care. The facility also holds contracts with the DHB to provide respite care, long-term support for chronic health conditions, palliative care and care for young people with physical or intellectual disabilities.</p> <p>The facility can provide care for up to 30 residents. Occupancy was 19 residents on the first day of audit. There were 10 residents were receiving hospital level care. This included 9 older persons, 7 of whom had occupational right agreements (ORA) and 1 under the intellectual disability under a YPD contract. At rest home level, there were 9 residents all of whom were older persons with ORAs in place.</p>
<p>Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to</p>	FA	<p>The service has appropriate systems in place to ensure the day-to-day operations of the service continues should the BCM or the CM be absent. The CM, with support from the regional clinical quality manager, stands in when the BCM is absent. The BCM stands in for the CM when away with support from the guest services manager.</p> <p>Both the BCM and CM are on call after hours if required. Oceania support office provides</p>

consumers.		additional assistance when needed.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	<p>Meadowbank Village Care Centre uses the Oceania Healthcare Limited quality and risk management framework. Organisational policies and procedures guide service delivery. Policies are subject to reviews. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation and evidenced based best practice guidelines. These are available to staff in hardcopy. New and revised policies are presented to staff to read and staff sign to confirm they have read and understood the policy. Staff interviewed stated they read new or revised policies. Staff interviewed reported they are kept informed of quality improvements.</p> <p>There are monthly meetings; joint quality and staff meetings; health and safety; infection control, restraint and falls; and RN. There are quarterly resident meetings which families/whānau have the opportunity to attend. Template agendas are used during meetings.</p> <p>Service delivery is monitored through review of complaints, incidents and accidents, surveillance of infections, pressure injury and soft tissue/wound reviews, and implementation of an internal audit programme. Review of the quality improvement data on the day of audit provided evidence the data is being collected, collated, evaluated, and analysed to identify trends and that this data is being reported to staff and to the governing body. Internal audit schedules and completed audits were reviewed and evidence corrective action plans were documented when applicable.</p> <p>Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. The health and safety manual documents health and safety management systems including a health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements, and an emergency plan. Meeting minutes are reviewed by management and provided evidence of discussion and reporting on accident/ incidents; hazards; staff wellness programme, health and safety objectives and maintenance.</p> <p>Resident/family satisfaction surveys are completed six monthly and results confirmed residents' satisfaction with the levels of care they receive. Resident interviews, including YPD, confirmed their participation in decision making, and having access to technology and the equipment they may need.</p>
Standard 1.2.4: Adverse Event Reporting	FA	The BCM is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease

<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>outbreaks and changes in key management roles. There has been no essential notifications or adverse events reported to HealthCERT or to any of the external agencies since the previous audit.</p> <p>Adverse, unplanned or untoward events are recorded on an accident/incident form. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the BCM. Accident/incident reports selected for review had corresponding corrective action plans. There is evidence of open disclosure for recorded events. Staff inform families after adverse events, as confirmed in clinical records and during family and resident interviews.</p> <p>Information is regularly shared at monthly meetings with accidents/incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities.</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>Meadowbank Village Care Centre have policies and procedures in relation to human resource management available and implemented. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and person reporting to. Review of staff files evidenced; employment agreements, reference checks, criminal vetting, drug testing, and completed orientation and competencies. Current copies of annual practising certificates were sighted for staff and contractors that require them to practise. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.</p> <p>The organisation has a mandatory education and training programme with an annual training schedule documented. Staff complete in-service training around a variety of clinical topics. An orientation/induction programme is available and new staff are required to demonstrate competency on a number of tasks, including but not limited to personal care and emergency and security systems. Health care assistants confirmed their role in supporting and buddying new staff. Individual staff attendance records and attendance records for each education session were reviewed and evidenced that ongoing education is provided.</p> <p>Four of five RNs have completed interRAI assessment training and competencies. Annual competencies are completed by care staff, for example: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; and restraint. Education and training hours are at least eight hours a year for each staff member. The RNs' training records reviewed evidenced eight hours or more of relevant training. Registered nurses are supported to attend external training to ensure they are continuing to build upon existing knowledge and skills.</p> <p>The appointment of service providers safely meets the needs of residents, including those with ORAs.</p>

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	<p>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. The staffing policy is the foundation for workforce planning.</p> <p>Rosters showed that staffing levels meet resident acuity and bed occupancy.</p> <p>There are 49 staff, including the management team, clinical staff, leisure/activity staff, and housekeeping staff. There is a RN on each shift. Care staff interviewed reported adequate staff are available and that they can get through their work. Residents and families confirmed staffing is adequate to meet the residents' needs.</p> <p>The residents who are receiving care in ORA units have their needs met within the environment in which they live with 24-hour care and sufficient staffing and availability of RNs to meet their needs in accordance with the aged related residential care agreement.</p>
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	<p>The service retains relevant and appropriate information to identify residents and track residents' records. This includes information collected on admission with the involvement of the family.</p> <p>There are policies and procedures in place for privacy and confidentiality of residents' records. The facility implemented a new, computerised, resident clinical management system four weeks prior to this audit. Interview with the Oceania clinical lead for this project was conducted and confirmed a transition plan from hard copy residents' records to fully computerised system has been implemented. Staff training had been conducted and staff interviews confirmed they are familiar with the electronic record management system. The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals which are either directly entered by the user or are scanned in to the system. Resident records in hard copy and electronic files are accessible by authorised personnel only.</p> <p>All components of the residents' records reviewed met legislative requirements. Resident care and support information can be accessed in a timely manner. Documents containing sensitive resident information are not displayed in a way that could be viewed by other residents or members of the public. Archived records are securely stored and easily retrievable.</p> <p>Staff described the procedures for maintaining confidentiality of residents' records.</p> <p>Residents' progress notes are completed on every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the</p>

		progress notes which identify the name and designation of the person making the entry.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	<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.</p> <p>Each potential resident who may be admitted for rest home or hospital level of care is assessed using the interRAI home care assessment tool in the six months before date of their admission. The facility information pack is available for residents and their family and contains all relevant information.</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 have been conducted.</p>
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	<p>The resident's exit, discharge or transfer is managed in a planned and coordinated manner. There is appropriate communication between families and other providers, that demonstrate transition, exit, discharge or transfer plans are communicated, when required. At the time of transition, appropriate information is supplied to the person/facility responsible for the ongoing management of the resident.</p>
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	<p>There is a computerised medication system in place with processes implemented to comply with current legislation requirements and safe practice guidelines. The medication areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The drug register is maintained and evidenced weekly checks and six-monthly physical stock takes. Regular records of temperature checks for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>All staff authorised to administer medicines have current competencies. A medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures.</p> <p>Processes are in place for residents to self-administer medicines if required. There were no</p>

		residents self-administering medicines at the facility on audit days.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	<p>There is a seasonal menu provided, that is 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 facilities. The registration expiry date of the food control plan is March 2019. Food temperatures are monitored appropriately and recorded as part of the food control plan. The food service staff have undertaken a safe food handling qualification and completed all relevant food handling training. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</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 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.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided.</p> <p>The facility has introduced a restaurant dining experience for residents at the facility and this is monitored by the guest services manager.</p> <p>Evidence of resident satisfaction with meals is verified by residents' and family interviews, sighted satisfaction surveys and residents' meeting minutes.</p>
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	<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>Residents would be declined entry if not within the scope of the service or if a bed was not available, as confirmed at management interviews.</p>

<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All residents have a file on the new electronic record management system and the required assessments on this programme have been completed. The assessment tool in the electronic record management system is based on best practice.</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 and family. The residents' files evidenced residents' completed discharge/transfer information from the DHB, where required.</p> <p>The clinical files reviewed evidenced not all residents had interRAI assessments completed within 21 days of their admission (refer to 1.3.3.3). The residents' files reviewed evidenced the residents had current interRAI assessments completed by trained interRAI assessors on site. 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. 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 Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<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 and the electronic record management system (refer to 1.3.3.3).</p> <p>The residents' care plans 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. Regular GP care is implemented, as sighted in current GP progress reports and confirmed at GP interview.</p> <p>Care plans evidence service integration with progress notes, activities notes, and medical and allied health professional's notes.</p>
<p>Standard 1.3.6: Service</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'</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents (refer to 1.3.3.3).</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' hard copy files and in the electronic record management system progress notes. Nursing progress notes and observation are maintained in the electronic record management system.</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, as 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>	<p>FA</p>	<p>The guest services manager oversees the activities/leisure programme at the facility. In interview with the guest services manager, the diversional therapist and the activities/leisure coordinator it was confirmed the activities programme meets the needs of the service group and the service has appropriate equipment.</p> <p>The residents are assessed on admission to ascertain their social needs and appropriate activity and social requirements. 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. The new residents are welcomed to the facility with a welcome party provided for the resident's family members and friends.</p> <p>The activities are provided seven days a week. Regular exercises and outings are provided for those residents able to partake. 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 on the electronic record management system. The residents' activity needs are evaluated as part of the formal six-monthly care plan review. The residents' activities attendance records are maintained on the electronic record management system and record the level of resident's involvement in the activities provided. Family/whānau and friends are welcome to attend all activities. The activity/leisure staff write in the activities progress notes weekly.</p> <p>The residents' meeting minutes and satisfaction surveys evidenced the activities programme is</p>

		<p>discussed and that management are responsive to requests. Family are invited to attend the residents' meetings.</p> <p>New activities have been introduced into the activities programme that are enjoyed by residents, such as: individualised music programmes and virtual reality, as one on one activities.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	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. Evaluations reviewed were residents' hard copy records and documented on the care plan evaluation form. The residents' care plans in the new electronic record management system were up to date and none were due for evaluation. Reassessments are completed using the interRAI assessments every six months or when changes in a resident's health status occur.</p> <p>There is evidence of resident, family, HCAs, activities staff and GP input into care plan evaluations. In interviews, residents and families confirmed their participation in care plan evaluations and multidisciplinary reviews.</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 in place in hard copy where required in residents' records reviewed. A short-term care plan is initiated for short-term concerns, such as infections, wound care, 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 and informed of all changes. The family is notified of any changes in resident's condition, confirmed at family interviews.</p>
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer	FA	<p>Appropriate processes and supports are in place to provide choices for residents in accessing or referring to other health and/or disability services. A multidisciplinary team approach is maintained and progress notes evidenced implementation.</p> <p>When required, referrals to non-urgent services are conducted by the GP or the RN. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.</p>

choice/needs.		CM and GP interviews confirmed any 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.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	<p>Documented policies and procedures provide guidelines for staff in the management of waste and hazardous substances. Policies and procedures specify labelling requirements in line with legislation, including the requirements for labels to be clear, accessible to read and free from damage.</p> <p>The hazard register is current. Material safety data sheets are available and accessible for staff. Staff receive training and education in safe and appropriate handling of waste and hazardous substances.</p> <p>Protective clothing and equipment that is appropriate to the recognised risks is provided. During a tour of the facility, protective clothing and equipment was observed in high risk areas.</p>
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	<p>There is a certificate of public use. A building warrant of fitness was displayed. There have been no building modifications since the last audit and the entrance to the facility has been completed. However, there is a fire door on the first floor leading to an internal stairwell which posed a risk of harm to hospital residents.</p> <p>The service provides mobility access throughout the facility, meeting requirements of residents including YPD. There are quiet areas throughout the facility for residents and their visitors to meet and there are areas that provide privacy when required. There is access to external garden areas with outdoor furniture and shade.</p> <p>Interview of the area maintenance supervisor and full time facility maintenance supervisor confirmed there is a planned and reactive maintenance schedule in place. The medical equipment had been checked and calibrated for safe use. The service has an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually. Interviews with staff and observation of the facility confirmed there is adequate equipment. The YPD resident confirmed having equipment that met their needs.</p> <p>Hot water temperature testing evidenced temperatures were within safe levels. Interviews with the maintenance supervisor confirmed that if the hot water temperatures exceed the recommended temperatures, corrective action is taken to address the issue.</p>

Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	<p>There are toilets provided close to the communal areas. Separate toilets are provided for visitors and the staff room has its own bathroom/toilet facility. All the toilets have a system that indicates if it is engaged or vacant.</p> <p>The bathroom facilities are of an appropriate design to meet the needs of the residents. Residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Residents and family members reported that there are sufficient toilets and showers. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.</p>
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	<p>There are 30 dual purpose care suites with a mix of studios and one bedroom apartments, all with full ensuite facilities. There is adequate space in both the one bedroom and the studio care suites for resident, staff and mobility equipment. All bedrooms are fitted with ceiling hoists. Interview with the maintenance supervisor confirmed the hoists are always on charge and are checked monthly.</p> <p>The residents' rooms are individualised with their own furnishings, photos and other personal possessions. Residents and families are encouraged to make the room their own.</p> <p>There were no residents sharing rooms at the time of the audit.</p>
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	<p>All lounge areas and dining areas are large enough to accommodate all residents. The service has three large lounge/dining areas that can be used for activities, one on the ground floor and two on the first floor, each with a kitchenette. All areas are easily accessed by residents and staff. Residents, including YPD, can access areas for privacy, if required.</p> <p>A café overseen by the food services manager is located adjacent to the kitchen, with tables and chairs for residents to have coffee. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. There is a gym with exercise equipment and a movie theatre.</p>
Standard 1.4.6: Cleaning And Laundry	FA	Facility level laundry is completed off-site. There are processes in place for daily collection, transportation and delivery of linen. Residents each have their own washing machine for

<p>Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>personal laundry.</p> <p>The effectiveness of the cleaning and laundry services is audited as part of the internal audit programme.</p> <p>There are cleaners on site during the day, seven days a week. There are safe and secure storage areas for chemicals and cleaning products. The chemicals are administered through a closed system which is managed by a chemical contractor company. The cleaners have a trolley to put chemicals in and the cleaners are aware that the trolley must be with them at all times. The cleaner has specific guidelines, in the form of a flip-chart, to ensure appropriate cleaning processes. Products are used with training around use of products provided throughout the year. The cleaner confirmed that they had training at least annually.</p> <p>Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility.</p> <p>Residents and families stated they were satisfied with the cleaning service.</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>	FA	<p>The service has documented systems in place for essential, emergency and security services. Registered nurses, HCA, the leisure/activities coordinator and the people who drive the van with residents in it, are required to complete first aid training. There are at least two designated staff members on each shift with first aid training. Emergency and security management education is provided at orientation and at the in-service education programme. Staff records sampled provided evidence of current training relating to fire, emergency and security.</p> <p>The entrance to the facility has a security system in place. Interviews with staff and review of rosters confirmed reception is operational seven days of the week. There is a system in place for security to ensure all entrances are locked after dark. Staff complete security checks at set intervals. Staff can identify visitors after hours when the security system is activated through the computer screen in the nurses' stations. Families and residents, including YPD, know the process of alerting staff when in need of access to the facility after hours. There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service. Visitors and contractors are required to sign in and out of visitors' registers, as observed on audit.</p> <p>A New Zealand Fire Service letter was sighted advising the fire evacuation scheme has been approved (refer to 1.4.2.4). The services' emergency plan considers the needs of YPD in an emergency.</p> <p>Information in relation to emergency and security situations is readily available/displayed for staff</p>

		<p>and residents. Emergency equipment is accessible, current and stored appropriately with evidence of emergency lighting, torches, gas and barbecue for cooking, extra food supplies, emergency water and blankets. There is motion activated lighting throughout the facility. Interview with the area maintenance supervisor confirmed there is access to a generator if required.</p> <p>The service has a call bell system in place that is used by the residents, family and staff members to summon assistance. All residents have access to a call bell. Call bells are checked monthly by the maintenance person. Residents confirmed they have a call bell 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>Policies and procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation and heating. Families and residents confirmed that rooms are maintained at an appropriate temperature. Interviews with the area maintenance supervisor and facility maintenance supervisor confirmed environmental temperatures are monitored quarterly.</p> <p>The facility is smoke-free for residents and service providers.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The facility provides an environment that minimises the risk of infection to residents, staff and visitors by implementing and maintaining an appropriate infection prevention and control programme. The CM is the infection control nurse (ICN). A documented job description for the ICN, including role and responsibilities is in place. Staff interviewed demonstrated knowledge of the infection prevention and control programme and practices.</p> <p>The infection prevention and control programme is appropriate for the size, complexity and degree of risk associated with this service. The facility has not been operational for a year at the time of audit, therefore, the infection prevention and control programme was not due for annual review.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents and visitors to use. Infection control audits are conducted and include hand hygiene and infection control practices.</p>
Standard 3.2: Implementing the infection	FA	<p>The ICN is responsible for implementing the infection prevention and control programme. The ICN stated on interview there are adequate human, physical, and information resources to</p>

<p>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>implement the programme. Infection control is a standard agenda item at the facility's meetings. The ICN has access to external infection control specialist advice, if required.</p> <p>Staff are made aware of residents' infections through staff handovers and residents' progress notes. The ICN has access to all relevant infection control 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 and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Oceania has documented infection prevention and control policies and procedures in place that reflect current best practice. The infection control manual includes a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and are current.</p> <p>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>
<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>Staff education on infection prevention and control is conducted by the ICN. Staff interviewed confirmed their understanding of how to implement infection prevention and control activities into their everyday practice. The ICN has attended relevant infection control education.</p> <p>Information is provided to residents and visitors that is appropriate to their needs.</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>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors.</p> <p>Staff interviewed reported that they are informed of infection rates at meetings and through compiled reports. The GP is informed when a resident has an infection and appropriate treatments are prescribed to combat the infection respectively.</p> <p>Residents' files evidenced the residents' who were diagnosed with an infection had short-term care plans in place.</p> <p>Monthly surveillance analysis is completed and reported at facility's meetings and entered in the</p>

		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. There have been no reported infection outbreaks at the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>The 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 restraints and enablers. 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 staff and management. On the days of the audit there was one resident using restraint. The review of the resident's file evidenced the process of assessment, care planning, monitoring and evaluation of restraint use was recorded and implemented.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews. There were no enablers used at the facility on audit days.</p>
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	<p>The Oceania clinical and quality team are responsible for approving any form or type of restraint practice used at Oceania facilities nationally. Oversight of the restraint use at each individual Oceania facility is the responsibility of the restraint coordinators. The restraint coordinator at Meadowbank is the CM and the responsibilities for this role are defined in the position description. The restraint coordinator demonstrated knowledge of the organisation's policies, procedures and practices relating to restraint and enabler use.</p> <p>Restraints are authorised following assessment of the resident. The approval includes consultation with other members of the multidisciplinary team. The consent for restraint use is obtained from the GP, restraint coordinator and the resident and/or a family member.</p> <p>In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice, enabler usage and prevention, challenging behaviours and/or de-escalation education and training is provided. Staff training in restraint use is included in orientation and ongoing education. Restraint competency testing of staff is included in the education of staff and competencies were current.</p>
Standard 2.2.2: Assessment	FA	The restraint assessment process is documented and includes the requirements of this standard.

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.		The resident's record sampled confirmed completed assessment and approval for the use of restraint. Restraint assessment is completed prior to commencement of any restraint. The restraint assessment reviewed evidenced the restraint coordinator's sign off and evidenced all appropriate factors were taken into consideration.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The protocols on safe use of restraint detail the processes of assessment, approval and implementation and these guide staff in the safe use of restraint. Strategies are implemented prior to the use of restraint to prevent the resident from incurring injury, for example: the use of low beds; mattresses and sensor mats. There have been no adverse outcomes or sentinel events relating to restraint use reported to the Oceania support office. The restraint register is up to date and records all necessary information to provide an auditable trail of restraint events. Restraint monitoring when the restraint is in use is documented.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Evaluation of restraint occurs through restraint event reporting by the facility to the Oceania support office. The clinical file of the resident using restraint evidenced the restraint evaluation was completed and included all the relevant factors in this standard. The restraint minimisation team meeting minutes evidence evaluation of each restraint use at the facility. The resident, if able, and the family are involved in the evaluation of the restraint's effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	There is evidence of monitoring and quality review of the use of restraints at the facility. The restraint meeting minutes evidence review of the compliance with the standard and includes: individual resident's restraint review; restraint register update; education review and any relevant restraint issues. Internal audits on the restraint use at the facility are completed and include detailed review of residents' clinical files of residents who use restraint. National restraint benchmarking and analysis is reviewed monthly by the clinical and quality managers. Annual review the compliance with the restraint standard and review of restraint use nationally is conducted by the Oceania support office staff. The Oceania restraint results indicate

		there has been reduction in restraint used nationally due to use of low beds and perimeter mattress surrounds.
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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)
Criterion 1.3.3.3 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.	PA Moderate	Review of the residents' clinical files evidenced the initial care plans are completed within the required timeframe. Three of the five residents' files did not have interRAI assessments completed within the 21 day timeframe. The long-term care plan requiring to be completed within the 21 days post residents' admissions are not recorded within that timeframe in three of five residents' files reviewed.	The interRAI assessments and the long-term care plans are not consistently completed within the required timeframes following resident's admission to the facility.	Provide evidence the interRAI assessments and the long-term care plans are completed within the required timeframes following resident's admission to the facility.

				90 days
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	The purpose built facility has a current certificate for public use, building warrant of fitness and fire evacuation certificate. A fire door on the first floor to an internal stairwell leading to the ground floor was accessible to hospital residents with dementia and posed a falls risk. A corrective action plan was put in place, the risk has been reduced, however, not yet evidenced as fully mitigated. Corrective actions and mitigation of the risk included; completion of a hazard form at the time of audit; communication with staff; a staff only sign erected on the fire door; and a touch pad exit button installed. There is evidence from management a controlled egress device is to be installed and that this device would need to be interfaced with the fire alarm and tested monthly.	A fire door on the first floor poses a risk of harm and requires evidence of full mitigation of risk.	Provide evidence the risk of harm has been fully mitigated, is linked to the fire system and fire evacuation plan has been updated to include the changes. 30 days

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 audit.

No data to display

End of the report.