

# Oceania Care Company Limited - Te Mana Home & Hospital

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## Introduction

This report records the results of a 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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Te Mana Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 27 November 2018    End date: 28 November 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	45

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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

Te Mana Home and Hospital (Oceania Healthcare Limited) can provide care for up to 46 residents requiring rest home or hospital level of care. The facility is certified to provide rest home, hospital, and residential disability - physical service. There were 45 residents at that facility on the first day of the audit.

This surveillance audit was conducted against the relevant Health and Disability Service Standards and the service contract with the district health board.

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

There were no areas requiring improvement at the last audit and no areas identified as requiring improvement at this surveillance audit.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is provided to residents on admission and available within the facility.

There is a documented complaints management system and a complaints register is maintained. The business care manager is responsible for managing complaints. Complaints are investigated and documented, with corrective actions implemented where required. There have been no complaints to external agencies since the last audit.

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

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

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Oceania Healthcare Limited is the governing body responsible for the services provided at Te Mana.

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement at the facility. Policies are reviewed. Monthly reports to the national support office allow for the monitoring of service delivery.

Quality and risk performance is monitored through the organisation's reporting systems. Benchmarking reports include but are not limited to: falls, infections, restraint, health and safety and complaints. An internal audit programme is implemented. Corrective action plans are documented with evidence of resolution of issues when these are identified. There is an electronic database to record risk in which risks and controls are clearly documented.

The facility is managed by an appropriately qualified and experienced business and care manager and supported by a clinical manager who is responsible for the oversight of clinical service provision. The clinical manager is a registered nurse. The facility management team is supported by the regional clinical quality manager and the regional operations manager.

Oceania Healthcare Limited human resource policies and procedures are implemented and newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff who require them are validated annually. An annual training plan is implemented to ensure ongoing training and education for all staff members.

A review of rosters and service delivery staff, and resident/family interviews confirmed that there is adequate staff available.

## 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.		Standards applicable to this service fully attained.
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Registered nurses are responsible for the provision of care and documentation of each stage of service delivery. Residents' records sampled demonstrated residents' needs, outcomes and/or goals have been identified in assessments. Allied health input and a team approach were evident in the residents' files reviewed. Short-term care plans are in place to manage short-term problems. The person centred care plans are reviewed every six months or earlier if required. Interviews confirmed residents and their

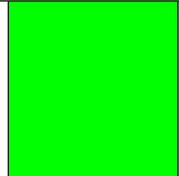
families are informed and involved in care planning and the evaluation of care. Handovers guide continuity of care. The general practitioner reviews residents at least monthly unless the resident's condition is documented as stable.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Special consideration and additional activities are provided for younger people with disabilities. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

Medicines management occurs according to documented policies and procedures, in alignment with legislative requirements and implemented using an electronic system. Medications are administered by registered nurses and senior health care assistants. Residents, including younger persons, are supported to self-administer medicines as appropriate. Medicines management competencies for staff who administer medicines are current.

The kitchen manager is responsible for food service provision. All meals are prepared on site. The food service meets nutritional requirements and individual dietary needs of the residents. The menu has been reviewed by a dietitian at organisational level. All kitchen staff had completed food safety training. Residents interviewed confirmed their satisfaction with the food service.

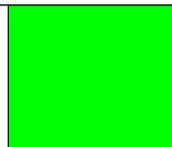
## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness. There had not been any alterations to the building since the last audit.

## Restraint minimisation and safe practice

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

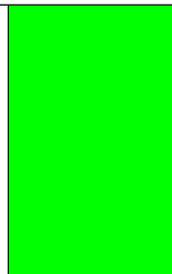


Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the clinical manager. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had five residents using restraint and two residents requesting the use of enablers. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary.

## 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 type of infection surveillance is appropriate to the size and complexity of the service. The clinical manager is the infection control nurse. Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Oceania Healthcare Limited support office. Review of surveillance records evidenced infection rates are low and infections are followed up when required. There have been no outbreaks since previous audit.

## 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	16	0	0	0	0	0
<b>Criteria</b>	0	40	0	0	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The BCM is responsible for managing complaints. An up-to-date complaints register is in place that includes: the date the complaint is received; a description of the complaint; the investigation undertaken; resolution and the date the complaint is signed off. Evidence relating to each lodged complaint is held in the complaints folder and on a complaints register. The complaints reviewed indicated that complaints are investigated promptly and issues are resolved in a timely manner.</p> <p>Staff and residents interviews confirmed that residents and family were encouraged to raise any concerns and provide feedback on services. Residents' meeting minutes confirm that the complaints process is re-iterated at the meetings. Residents and family interviews confirmed that they were aware of a complaints process and that they could make a complaint. They stated that any issues raised had been dealt with effectively and efficiently. Residents and family interviews confirmed an understanding of their rights to advocacy and how to access advocacy services particularly in relation to the complaints process.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit.</p>
<p>Standard 1.1.9: Communication</p>	<p>FA</p>	<p>There is an open disclosure policy that sets out the process to guide staff to ensure there is open disclosure of any adverse event where a resident has suffered any unintended harm while receiving care. Completed incident</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>forms and residents' records demonstrated that family are informed if the resident has an incident/accident; a change in health or a change in needs. Family and resident interviews by the consumer auditor confirmed that family are informed of any changes in resident status and that they are invited to the care planning meetings for the resident.</p> <p>Two monthly resident meetings inform residents of facility activities and provide an opportunity to: make suggestions; provide feedback; and to raise and discuss issues/concerns with management. These are advertised on the resident notice board and family are invited to attend the meetings. Minutes of the residents' meetings sighted evidenced that a range of subjects are discussed. Residents and family have access to the minutes from these meetings and minutes are available in large print for ease of reading. Residents and family are also provided with copies of upcoming planned activities and menu. There is a monthly newsletter which includes events and updates such as, seasonal events, hairdresser appointment times. Interviews confirmed that the BCM and staff were readily available, approachable and responded promptly to any issues/concerns raised.</p> <p>There is policy that provides guidance and procedures for staff to ensure that residents who do not use English as their first language are offered the availability of interpreting services. It states that staff have access to a list of interpreting services and family may only interpret with a resident's consent. The facility had implemented a process to facilitate effective communication with one resident with a communication impairment. At the time of the audit there was one resident for whom English was not their first language and there were two staff, as well as family members, who were able to assist with interpretation when required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Oceania Healthcare Limited (Oceania) has a documented vision, mission and values statement which is displayed in entrance to the resident lounge/dining area and reflects a person centred approach to all residents, including young people with disabilities (YPD). These are communicated to residents, family and staff through the internet and information provided to new residents and families on admission. Staff also receive this information in annual training. In addition to the overarching Oceania business plan, the facility has specific business planning objectives that are included within their annual budget specific to Te Mana.</p> <p>The facility is part of the Oceania group with the executive management team providing support to the facility. Communication between the facility and executive management occurs monthly with the clinical and quality and operations managers providing support during the audit. The monthly reports from the facility provides the executive management team with progress against identified indicators.</p> <p>The BCM is supported by a clinical manager (CM). The BCM has been in the role for one year and has completed the Oceania managers training. The BCM has previous administration experience within aged residential care. The CM has been working in the facility as a registered nurse (RN) for six years and has been in the CM role for two years. The CM holds a current annual practising certificate and is supported by the Oceania clinical and quality manager (CQM). The management team have completed appropriate induction and</p>

		<p>orientation to their roles.</p> <p>Te Mana Home and Hospital can provide services for up to 46 residents. The facility is certified to provide rest home, hospital, and residential disability - physical services with 45 beds occupied at the time of the audit. Occupancy included: 9 residents requiring rest home level care; and 22 requiring hospital level care. In addition there were 14 residents classified under the chronic conditions – under 65 years YPD contract, including 5 who were assessed as requiring long-term respite care.</p> <p>Thirteen of the YPD residents had been assessed as having a physical/sensory disability and one with an intellectual disability. Five of the YPD residents had been assessed as requiring rest home level care and nine as requiring hospital level care.</p> <p>The facility does not have any occupational right agreements.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The facility utilises Oceania’s documented quality and risk management framework that is available to staff to guide service delivery. Policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies are presented to staff at staff meetings and policy updates are also provided as part of relevant in-service education. New and revised policies are also made available on a notice board in the staff room and staff sign to confirm that that they have read and understood each new policy and/or update. Staff interviews confirmed that they are made aware of new and updated policies.</p> <p>Service delivery is monitored through the organisation’s reporting systems utilising a number of clinical indicators such as: complaints; falls; infections; wounds; urinary tract infections; incidents and accidents; medication errors and implementation of the internal audit programme. There is evidence that the annual internal audit programme is implemented as scheduled. Reports evidence that quality improvement data is being collected and collated with the identification of trends and analysis of data. Where required, corrective action plans are developed, implemented, evaluated and closed out. There is communication with all staff of any subsequent changes to procedures and practice through meetings and staff notices.</p> <p>Residents and family are notified of updates through the facility’s residents’ meetings. Residents’ meeting minutes confirmed that YPD residents have the opportunity to have input into quality improvements and facility equipment. Interviews by the consumer auditor confirmed that YPD residents are satisfied that services meet their individual needs and that they have input into services.</p> <p>Quality and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. Staff interviews reported that they are kept informed of quality improvements. Copies of meeting minutes are available for review in the staff room and staff sign to confirm that they have read and understood these. Staff interviews and meeting attendance records confirmed that attendance at staff meetings</p>

		<p>was encouraged and facilitated.</p> <p>Satisfaction surveys for residents and family are completed as part of the internal audit programme and these evidenced satisfaction with services provided. This was confirmed by resident and family interviews.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly. There is a nominated health and safety representative for each staff group and interviews confirmed a clear understanding of the obligations of the role. Staff interviews confirmed an awareness of the process and responsibility to report hazards. There is evidence of hazard identification forms completed when a hazard is identified and that hazards are addressed and risks minimised. A current hazard register is available that is reviewed and updated annually or when a new hazard is identified.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The BCM is aware of situations which require the facility to report and notify statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. These are reported to the appropriate authority via Oceania support office staff. Interviews confirmed that there had been no events that required reporting since the last audit.</p> <p>Staff interviews and review of documentation confirmed that staff document adverse, unplanned or untoward events on an accident/incident form which are signed off by the BCM.</p> <p>Staff interviews confirmed that they are encouraged to recognise and report errors or mistakes. Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. Staff records reviewed demonstrated that staff receive orientation and education on the incident and accident reporting process.</p> <p>Incident reporting forms are readily available. Incident reports selected for review evidenced that the resident's family had been notified, an assessment had been conducted and observations completed. Corrective actions arising from incidents were implemented. There is evidence of a corresponding note in the resident progress notes and notification of the resident's family member where appropriate.</p> <p>Accident/incidents are graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Accident/incidents are also discussed at quarterly regional cluster meetings. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared at monthly staff meetings.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; identification verification; a position specific job description; and a signed employment agreement.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that require them including: RNs, the pharmacists, general practitioner (GP), dietitian, and podiatrist.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks, including personal cares.</p> <p>The organisation has a documented role specific mandatory annual education and training module/schedule. There are systems and processes in place to ensure that all staff complete their required mandatory training modules and competencies.</p> <p>The CM and four other RNs have completed interRAI assessments training and competencies. Care staff complete annual competencies, for example: moving and handling; hoist use; hand washing; and infection control. Education session attendance records evidenced that ongoing education is provided relevant to the services delivered including services for YPD residents. Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of relevant education and training hours per annum. An appraisal schedule is in place and all staff files reviewed for staff employed greater than one year, evidenced a current performance appraisal.</p> <p>The facility's staffing rationale informs recruitment processes to ensure that sufficient suitable staff are appointed and available to meet the needs of all residents including those with non-acute medical conditions.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The facility currently has 48 staff consisting of: a management team; RNs; health care assistants (HCA); activities coordinator; and household staff. Household staff include: kitchen and housekeeping staff who provide services seven days a week.</p> <p>The organisation's staffing and skill mix policy and formula provide guidance to ensure safe staffing levels within the facility are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract. Rosters are formulated two weeks in advance and staffing levels are reviewed to accommodate anticipated workloads, identified numbers, and appropriate skill mix, or as required due to changes in the services provided and the number of residents.</p> <p>There are sufficient RNs and HCA, available to safely maintain the rosters for the provision of care. There is a pool of casual RNs, and HCAs available to supplement rosters when needed to accommodate increases in workloads and the acuity of residents such as additional hospital level residents. Rosters sighted reflected</p>

		<p>adequate staffing levels to meet current resident acuity and bed occupancy and demonstrated that there is at least one RN on each shift.</p> <p>The BCM and CM are on call after hours, seven days a week.</p> <p>Observation of service delivery confirmed that resident needs were being met in a timely manner. Residents and family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed that they have sufficient time to complete their scheduled tasks and resident cares.</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>	FA	<p>The medication management system and policies and procedures comply with medication legislation and guidelines. Medications are checked against the resident's medication profile on arrival from the pharmacy by a RN. Any errors by the pharmacy are regarded as an incident and referred back to the pharmacy. Review of the medication area 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 stocktakes.</p> <p>An electronic medication management system is used at the facility and meets the current legislative requirements and safe practice guidelines. Three-monthly medication reviews are conducted by the GP and any discontinued medicines are dated and signed by the GP. Medication administration observed met legislative requirements. Administration records are maintained. There is evidence outcomes are recorded for as required pain medication administered.</p> <p>Staff attend annual medication education. Staff administering medicines, including RNs and senior HCAs, have completed medication competencies.</p> <p>The fridge where medications are kept, has a weekly temperature check within the recommended range.</p> <p>There were no standing orders in use at time of audit. There is a policy and process that describes self-administered medicines. Younger persons are supported to self-administer medicines where appropriate. There were no residents who were self-administering their medication at time of audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of</p>	FA	<p>The kitchen manager oversees food provision at Te Mana. They are supported by two cooks and four kitchen assistants. Food services comply with current legislation and guidelines. A food control plan last reviewed in September 2018 is located in the kitchen. All kitchen staff have completed food safety certificates or relevant training. The four weekly seasonal menu has been reviewed by a dietitian annually at organisational level. All food is stored as required. A regular cleaning schedule is implemented. Refrigerator and freezer temperatures are maintained. Food audits are carried out as per the yearly audit schedule.</p> <p>Temperatures are taken of end cooked food and of food prior to serving. Meals are prepared and served to</p>

<p>service delivery.</p>		<p>residents in the main dining room. A tray service is provided as required.</p> <p>Residents' dietary profile is completed by the RN on admission, identifying the residents' dietary requirements and preferences. There were current copies of the residents' dietary profiles located in the kitchen. Diets are modified as required. Interview with the CM and kitchen manager confirmed high protein drinks are supplied for those residents identified as being at risk of weight loss. Review of residents' monitoring records confirmed residents weights are documented monthly and weights are stable. Observation at lunchtime confirmed those residents requiring extra support to eat and drink are assisted by staff.</p> <p>Residents and families interviewed confirmed 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 and desired outcomes.</p>	<p>FA</p>	<p>In files sampled wound care plans, nutrition managements, skin integrity managements, medical specific plans, pain management and falls prevention plans were evident. There is evidence of referrals to specialist services such as: podiatry; physiotherapy; speech language therapist; dietitian and wound specialist nurses. The use of short-term care plans was evident where required.</p> <p>Nursing progress notes and observation charts are maintained. Family communication is recorded in the residents' files. Files sampled evidenced at least six monthly care plan reviews were completed.</p> <p>There were sufficient supplies of products and equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p> <p>The care provided is consistent with the needs of the residents. Staff interviews confirmed they are familiar with the needs of the residents they are allocated to. This was also evidenced by discussions with residents and families. The GP interviewed was complimentary about the quality of the service provided.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Interview with the activities coordinator and review of residents' files confirmed an individual activities plan is developed for each resident. Residents have an activities assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career and family. A memory lane booklet provides a profile and life journey for each resident. Files reviewed evidenced activities assessments and reviews were up to date.</p> <p>The residents' activities programme is developed and implemented by the activities coordinator. The activities programme provides a range of planned activities to maintain residents' strengths and interests which include the involvement of the community. Interview with the activities coordinator confirmed they conduct bi-monthly residents' meetings and that younger residents were provided with time to plan activities of their choice. Review of meeting minutes indicated residents' input is sought and responded to. Interviews with residents and families confirmed activities provided are meaningful to them.</p>

		<p>The service had younger persons' with specific care plans including additional social activities and community links to meet their specific needs. On the day of audit, residents including younger persons, were observed being actively involved with a variety of activities in the main lounge. Some residents attend activities of interest in the community. The facility provides weekly van outings. There is a specific weekly van outing for younger residents to accommodate shopping, banking and other needs. Residents who prefer to stay in their room can have one-on-one visits including, for example, reading, hand massage and music.</p> <p>The residents' attendances and participation in activities are monitored and activities monthly progress reports are entered in the residents' clinical files. The activities coordinator interviewed stated that they participate in six monthly multidisciplinary meetings as part of the formal six-monthly care plan review.</p> <p>The residents and their families interviewed reported satisfaction with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>There was documented evidence that RN evaluations were current and completed for all care plans sampled. Reviews include the degree of achievement towards meeting desired goals and outcomes. Resident care is evaluated on each shift and reported in the residents' progress notes. If any change is noted it is reported to the RN or the CM.</p> <p>A short-term care plan is initiated for short-term concerns, such as infections and wound care. Interviews verified residents and family/whānau are included and informed of all changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed in the entrance to the current facility. There have been no building alterations to the facility since the last audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and</p>	FA	<p>The Oceania Healthcare Limited surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed. The CM is the infection control nurse (ICN). Infection data is collated monthly by the CM and is submitted to Oceania national support office where benchmarking is completed. This data is analysed for trends and reported at the monthly infection control meeting and at the monthly staff and quality meeting for all staff.</p>

<p>methods that have been specified in the infection control programme.</p>		<p>Interview with the CM confirmed there had been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The Oceania Healthcare Limited restraint minimisation and safe practice handbook and policies comply with legislative requirements. The restraint coordinator is the CM. A signed position description was sighted. The Oceania clinical and quality team are responsible for approving any form or type of restraint practice used at Oceania facilities nationally. Restraint is only used as last resort once all alternative strategies are considered. Enablers are voluntary and the least restrictive option is in use to maintain resident independence and safety.</p> <p>The restraint register is maintained and current. There were five residents using restraint and two residents using enablers during the on-site audit days. The required documentation relating to restraint is recorded.</p>

## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.