

Oceania Care Company Limited - Victoria Place Rest Home/Hospital and Dementia Care

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:

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| Legal entity: | Oceania Care Company Limited |
| Premises audited: | Victoria Place Rest Home/Hospital and Dementia Care |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 31 January 2019 End date: 1 February 2019 |
| 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: | 47 |



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

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

General overview of the audit

Victoria Place Rest Home/Hospital and Dementia Care is part of Oceania Healthcare Limited. The facility can provide services for up to 51 residents requiring rest home, hospital or dementia level of care. There were 47 residents at that facility on the first day of the audit.

This certification audit was conducted against the Health and Disability Service Standards and the facility's contract with the district health board. The audit process included the review of policies and procedures, review of resident and staff files, and observations and interviews with residents, family members, management, staff, and a general practitioner.

There was one area identified at this audit as requiring improvement relating to maintenance.

Consumer rights

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

Staff interviews demonstrated an understanding of residents' rights and obligations. Residents and family members confirmed their rights are being met; staff are respectful of their needs and that communication is appropriate.

Residents' cultural and spiritual beliefs are identified on admission and there is access to cultural and spiritual support if required. Informed consent is practised and written consent is obtained when required.

Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents. Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

Staff communicate with residents and family members following any incident and this is recorded in the resident's file. Residents, family and general practitioner interviews confirmed that the environment is conducive to communication, issues are identified where applicable, and that staff are respectful of residents' needs.

There is a documented complaints management system that aligns with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Complaints are investigated and documented, with corrective actions implemented where required. A complaints register is maintained.

Organisational management

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| 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 this facility. The mission, vision and values of the organisation are documented and communicated to all concerned.

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement meetings. Facility meetings are held that include reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

The facility has an incident and accident management system to record and report adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting.

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

Human resource policies and procedures guide practice and there is evidence that human resource processes are being followed. Staff receive orientation relevant to their role and ongoing training is provided. There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. Staffing levels are adequate across the services.

Systems are in place to ensure the consumer information management system is protected from unauthorised access

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Standards applicable to this service fully attained. |
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All residents are assessed by the Needs Assessment and Service Coordination Service prior to admission. Residents and families are provided with information as required.

The service has a multidisciplinary approach to service delivery. Recognised tools are used for assessments and care plans are individualised based on the range of information provided. The records reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated regularly and timeframes are met. Residents are referred and transferred to other health and disability services as needed.

The activities programmes provide residents with a variety of individual and group activities. One on one activities are also provided as required. Maintaining links to the community is encouraged.

Safe medication management was observed by staff who are competent to administer medicines. Medication reviews are performed by the general practitioners three monthly and as required.

The food service meets the nutritional needs of all residents and those with special requirements have these catered for. A food control plan is in place. Residents and families verified satisfaction with meals.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Some standards applicable to this service partially attained and of low risk. |
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There is a current building warrant of fitness and an approved fire evacuation plan. Six monthly trial evacuations are undertaken.

A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes equipment and electrical checks.

Residents' rooms 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. Bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has a monitored call bell systems for residents to summon help, when needed, in a timely manner.

There are documented and implemented policies and procedures for cleaning and waste management. Cleaning and laundry services are provided seven days a week by household staff and are monitored.

Essential security systems are in place to ensure resident safety.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |
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The organisation has implemented policies and procedures for restraint minimisation and safe practice. One enabler and two restraints were in use at the time of the audit. A restraint assessment, approval and monitoring process is documented and implemented. The use of an enabler is voluntary for safety reasons and staff interviewed had sound knowledge of the restraint and enabler process. There is a designated restraint coordinator.

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.

An experienced infection control nurse leads the infection prevention and control programme. The programme aims to prevent and manage infections for residents', staff and visitors to Victoria Place. The programme is reviewed annually. Specialist advice can be sought and accessed when required. Staff interviewed demonstrated an understanding of the principles of infection prevention and control. Infection control education is provided at orientation and this is ongoing. Aged care specific infection surveillance is undertaken and results are reported to the clinical manager and all levels of the organisation. Feedback is provided to staff and follow-up action is taken if needed.

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) |
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| Standards | 0 | 49 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 100 | 0 | 1 | 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) |
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| 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 |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | <p>FA</p> | <p>There are implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code).</p> <p>All staff have received education on the Code as part of orientation and the annual education programme. Staff interviews confirmed their understanding of the Code and their obligations. Evidence that the Code is implemented in their everyday practice includes, but is not limited to, maintaining residents’ privacy; providing residents with choices; encouraging independence; involving residents and family in decision making and ensuring residents are able to practise their own personal values and beliefs.</p> <p>Residents and family interviews and observation confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff are respectful towards residents and their families and residents receive information relevant to their needs.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their</p> | <p>FA</p> | <p>The organisation’s informed consent policy provides the guidelines to ensure that all residents or their family will be informed about the management and care to be provided in order that they may arrive at a reasoned and non-pressured decision about any proposed treatment or procedure. It describes what consent involves and how it may be facilitated, obtained, refused and withdrawn. Cultural considerations are identified such as</p> |

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| <p>family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | | <p>the involvement of the wider whānau and allowing time for decision making. It ensures that staff members adhere to the legal and ethical requirements of informed consent and informed choice for health care services and service provision. The policy includes, for example, guidelines for consent for treatment, photographs, specific cares, collection and storage of information, and advance directives.</p> <p>The information pack provided on/prior to admission includes information regarding informed consent. The BCM or CM discusses this with residents and their families during the admission process to ensure understanding. Staff receive orientation and training on informed consent and staff interviews confirmed they are aware of the informed consent process.</p> <p>There is an advance directives and an end of life decision policy to ensure that appropriate ethical concepts are upheld in resident treatment and care situations in relation to end of life. The policy defines the procedure for obtaining an advance directive and who may or may not make an advance directive. File reviews demonstrated that advance directives and resuscitation orders were completed in accordance with policy.</p> |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | <p>FA</p> | <p>There is an advocacy policy and procedure for staff to follow to ensure that residents and their families have a right to be represented and express views or concerns about their situation. It includes making them aware of the availability of advocacy services and supports access to advocacy services. Information regarding the availability of the Nationwide Health and Disability Advocacy Service is provided in the information packs provided to residents and family prior to/on their admission to the facility. Additional advocacy services brochures are also available at the entrance to the residents' dining room. The complaints policy also includes making residents aware of their right to advocacy when making a complaint.</p> <p>Advocates regularly attend the facility to ensure resident access to the service.</p> <p>Family and resident interviews confirmed that the facility provides opportunities for the family to be involved in decisions, they are aware of the right to advocacy and the advocacy services available.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | <p>FA</p> | <p>Observations and resident and staff interviews confirmed that residents may have access to visitors of their choice at any time. There are areas where a resident and family can meet in private. Observations and resident and family interviews confirmed that families were made to feel welcome in the facility.</p> <p>Interviews confirmed that residents are able to maintain existing community involvement with family and social networks. Resident interviews confirmed that residents are free to leave the facility when they so choose, for example, to be involved in local community and social activities and family outings. The activities programme and the content of care plans include regular outings in the community.</p> <p>Staff interviews stated that residents under the young people with disabilities (YPD) contract are supported</p> |

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| | | and encouraged to access activities and resources in the community as well as family and networks if they so choose.. Resident interviews confirmed that the facility supported them to maintain linkages within the community. |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The organisation's complaints policy outlines the complaints procedure that is in line with the Code and includes the expected timeframes for responding to a complaint. The complaint process and forms are made available as part of the admission pack and explained by the CM or registered nurse (RN). Residents and their families are reminded of the complaints process at resident meetings. The complaint forms are also available at the entrance to the facility.</p> <p>The BCM is responsible for managing complaints. Interview and a review of complaints demonstrated there had been one complaint since the previous audit. Documentation evidenced the complaint was investigated promptly and issues resolved in a timely manner. The complaint had been added to the complaints register. The complaint register includes the date the complaint was received; the source of the complaint; a description of the complaint; resolution, and the date the complaint was signed off. Evidence relating to complaints is held in the complaints folder and register.</p> <p>Staff interviews confirmed that residents and family were encouraged to raise any concerns and provide feedback on services. Residents and family interviews confirmed that they were aware of the complaints process and would not hesitate to make a complaint if needed. Residents stated that they could raise any issues directly with management and that these are dealt with effectively and efficiently. Residents and family interviews confirmed an understanding of their rights to advocacy and how to access advocacy services in relation to the complaints process.</p> <p>There have been no complaints lodged with external agencies 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>New residents and their families are provided with information about the Code as part of an information pack provided on admission to the facility. The business care manager (BCM) or clinical manager (CM) also explain the Code to ensure understanding during the admission process. The pack includes information on the complaints process and advocacy service.</p> <p>The Code and associated information is also available in information brochures which are displayed at the entry to the facility and available to take away and read in private. Information on the Code is also displayed in posters in English and te reo Māori. A resource folders is held with a selection of brochures on the Code in multiple languages, for residents and their families who may wish to access these.</p> <p>Advocacy services are accessed locally through Age Concern and the Tokoroa Council of Social Services for residents if required. These can also be accessed through the Nationwide Health and Disability Advocacy</p> |

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| | | Service. The advocacy service also holds a three-monthly meeting for residents and their families in the facility to discuss services and advocacy. |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>The organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code and ensure that a resident's right to privacy and dignity is upheld.</p> <p>Interviews and observation confirmed that staff knock on bedroom and bathroom doors prior to entering rooms and ensure that doors were shut when personal cares were being provided. Interviews and observation confirmed that conversations of a personal nature were held in private. Residents and families stated that they felt that a resident's right to privacy is upheld.</p> <p>The organisation has a policy on sexuality and intimacy that acknowledges residents' rights to privacy and intimacy as identified by each resident. It includes identifying resident needs; and responding to expressions of sexuality. Observation and staff, resident and family interviews confirmed that residents were able to wear their own choice of clothing, make up and accessories.</p> <p>Resident files, interviews and satisfaction surveys confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented, and upheld.</p> <p>There is an abuse and neglect policy that sets out the guidelines to: prevent; identify; report and correct incidences of abuse and neglect. It includes managing the risk to residents and staff arising from abuse or neglect. Staff receive orientation and annual training on abuse and neglect. Staff at interviews identified staff are aware of their obligations to report any incidences of suspected abuse. There were no documented incidents of abuse or neglect. Staff, resident, and family interviews confirmed that there was no evidence of abuse or neglect.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | FA | <p>The organisation has a Māori health plan/policy that demonstrates Oceania Healthcare Limited's (Oceania) commitment to ensuring residents who identify as Māori have their needs met in a manner that respects and acknowledges their individual and cultural values and beliefs. There is also a cultural competent services policy that describes for staff how culturally competent services should be delivered.</p> <p>Support for staff in providing culturally appropriate care, and for Māori residents and their families, can be sourced if required through linkages with a local Māori education provider, kaumātua, elders and staff who identify as Māori. Staff receive training in cultural safety and values and Māori health at orientation and as well as part of the mandatory annual education programme. There were five residents identifying as Māori at the time of audit.</p> <p>Staff and resident interviews felt that the needs of Māori residents were respected and met in a culturally</p> |

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| | | competent manner. Service delivery interviews confirmed that staff were aware of the importance of the involvement of immediate and wider whānau in the delivery of care for Māori residents. |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | FA | <p>Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family are involved in the assessment and the care planning processes.</p> <p>Information gathered during assessments includes identifying a resident's specific cultural needs, spiritual values, and beliefs. A review of residents' files confirmed that specific cultural needs identified in assessments are reflected in the residents' care plans. Assessments also include obtaining background information on a resident's spiritual and cultural preferences, which includes but is not limited to beliefs; cultural identity; and church attendances. This information informs activities that are tailored to meet identified needs and preferences.</p> <p>The ethnic makeup of staff; inclusive of Māori and Pacific people, is reflective of the resident population.</p> <p>The spirituality and counselling policy ensures access for residents to a chosen spiritual advisor or counsellor. Residents have the opportunity, if they choose, to attend weekly church services held through the local Pacific Island church. In addition, a lay person provides a spiritual reading daily for residents in the lounge and a catholic priest will visit residents and provide communion to those who wish to receive it. Residents are supported to attend church services in the local community and other activities such as the catholic women's morning tea.</p> <p>Resident interviews and surveys confirmed that the services were responsive to individual resident's cultural and spiritual needs.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | <p>There is policy to ensure the environment for residents is free from discrimination; coercion; harassment; and financial exploitation. The policy describes for staff how this will be prevented and, where suspected, reported.</p> <p>Job descriptions include the responsibilities of the position, including ethical issues relevant to each role. Staff interviews confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation.</p> <p>There were no complaints or incidents recorded since the previous audit relating to any form of discrimination, coercion or harassment.</p> <p>Staff are required to abide by the Oceania code of conduct. Orientation and staff mandatory training includes the code of conduct, inclusive of professional boundaries. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Resident and family interviews confirmed that staff</p> |

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| | | maintain appropriate professional boundaries. |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <p>The facility implements the Oceania policies and procedures which are current and based on good practice and current legislation and guidelines. The policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice.</p> <p>There are relevant training programmes for all staff. Benchmarking occurs across all the Oceania facilities. Results of benchmarking and changes to practice and policy are made available to staff through monthly meetings.</p> <p>Staff, resident and family interviews, residents' file notes and observation of service delivery confirmed that resident care was based on good practice guidelines</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>There is an open disclosure policy that sets out the process to guide staff to ensure there is open disclosure of any adverse event where a resident has experienced any unintended harm while receiving care. Completed incident forms, residents' records and family interviews demonstrated that family are informed if the resident has an incident/accident; a change in health or a change in needs. Family contact is recorded in residents' files and on incident forms.</p> <p>Family and resident interviews confirmed that family are included in resident care planning. Monthly residents' meetings inform residents of facility activities. Meetings also provide an opportunity to raise and discuss issues/concerns with management. Minutes of the residents' meetings sighted provided evidence that a wide range of subjects are discussed such as, but not limited to, health and wellbeing in the hot weather; laundry and labelling clothes; upcoming outings, entertainers and events; new staff and cleaning. Family are welcome to attend upcoming residents' meetings. Any changes to policy that could impact on residents, or their families, are discussed at the meeting. Every third meeting an advocate attends and meets separately with residents, without staff present. Residents and family are provided with a copy of the minutes from these meetings. Copies of the activities planned and the menu are also available to residents.</p> <p>The facility has implemented a gazette/newsletter to inform residents and their families of updates and events. It provides information and updates on a range of subjects such as but not limited to upcoming events such as outings and celebrations; as well as a recap on activities that have happened. Residents and family interviews confirmed that the BCM and CM were approachable and available to discuss services and issues with residents and their families.</p> <p>There is policy that provides guidance and procedures for staff to ensure that residents who do not use English as their first language are offered interpreting services. It states that staff have access to a list of interpreting services and family may only interpret with a resident's consent. Interviews confirmed that</p> |

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| | | <p>interpreter services would be accessed through the district health board (DHB), if required. At the time of the audit there were no residents who required an interpreter.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>The facility is part of the Oceania Group with the executive management team providing support to the facility. Communication between the service and Oceania executive management occurs monthly with the clinical and quality manager providing support during the audit. The monthly facility business status report provides the executive management with progress against identified indicators.</p> <p>Oceania has a documented mission statement, vision and values. These are displayed at the entrance to the facility.</p> <p>In addition to the overarching Oceania business plan, the facility has a draft budget for 2019. The budget demonstrates current business plans and capital expenditure for the year.</p> <p>The facility is managed by a BCM who is supported by a CM. The BCM has been employed by Oceania for eight years and has been in their current role for five years. Prior their appointment to their current role, they were the CM for three years at this facility. The BCM has completed Oceania leadership training. The clinical care at the facility is overseen by the CM. The CM is a RN who has previous experience as a RN and CM in another aged residential care (ARC) facility. The CM has been in this position for one month. The management team is supported in their roles by the Oceania executive and regional teams and have completed induction and orientation appropriate to their respective roles.</p> <p>The facility is certified to provide rest home, hospital level and dementia care and currently provides care for up to 51 residents. There are 44 dual purpose beds and 7 dementia beds. There were 47 beds occupied at the time of the audit. Occupancy included: 23 residents requiring rest home level care; 17 requiring hospital level care; and 7 requiring dementia level care.</p> <p>The facility has contracts with the DHB for the provision of rest home and hospital level care; dementia care; respite care; and a contract with the Ministry of Health for residential non-aged care (YPD services). Included in total occupancy numbers were two residents assessed at hospital level care under the YPD agreement.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective</p> | FA | <p>During a temporary absence of the BCM, the regional clinical and quality manager, and the regional operations manager would provide support to the facility. The new CM will step up in the absence of the BCM once settled and established in the current CM role.</p> <p>In the absence of the CM, the BCM assisted by RNs will, with the support and help of the regional clinical and quality manager, ensure continuity of clinical services.</p> |

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| <p>manner which ensures the provision of timely, appropriate, and safe services to consumers.</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.</p> <p>All policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The Oceania management group reviews all policies with input from relevant personnel. Staff are emailed and advised of new and revised policies. These are also presented to staff at staff meetings, on the staff noticeboard and policy updates are provided as a part of relevant in-service education. Training records demonstrate that staff sign to confirm acknowledgement of a new or revised policy. Staff interviews confirmed that they are advised of new and updated policies.</p> <p>The service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators such as: incidents and accidents; surveillance of infections; pressure injuries; falls; and medication errors.</p> <p>There was evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data provides evidence that 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 staff of any subsequent changes to procedures and practice through meetings and staff notices.</p> <p>Residents and family are notified of relevant updates through the facility's resident meetings. Quality, health and safety, and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. Staff reported that they are kept informed of quality improvements. Copies of meeting minutes are available for review in the staff room for staff who were unable to attend a meeting.</p> <p>Satisfaction surveys for residents and family are completed as part of the internal audit programme. The results of internal audits are collated and evidence satisfaction with services. Resident and family interviews confirmed satisfaction with services.</p> <p>The organisation has a risk management programme in place that records management of risks in clinical, environment, human resources and other areas specific to the facility. 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 the need to report hazards, accidents and incidents promptly.</p> <p>There is a nominated health and safety representative who has been in the role for approximately nine months. Interview confirmed that the representative has a clear understanding of the obligations of the role.</p> |

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| | | There was evidence of hazard identification forms being completed when a hazard is identified and that hazards are addressed and risks minimised. A current hazard register is available and is reviewed and updated annually or upon identification of a new hazard. |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>Policy and procedures reference essential notification reporting; for example, health and safety, human resources, and infection control. 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 by the Oceania support office. The new appointment of the CM in December 2018 has been reported to HealthCERT. There has been one notification of an infectious disease outbreak to Public Health Unit since the last audit.</p> <p>Staff interviews confirmed that all staff 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 education at orientation and in the annual training programme on the incident/accident reporting process.</p> <p>There is an implemented accident/incident reporting process and incident/accident reporting forms are available throughout the facility. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on an accident/incident form which is signed off by the BCM. Incident/accident reports selected for review evidenced the resident's family had been notified where appropriate, an assessment had been conducted and observations completed. There is evidence of a corresponding note in the resident progress notes relating to the notification of the resident's nominated next of kin where appropriate. Staff complete incident/accident form if they experience an incident or accident and these are investigated using root cause analysis. Corrective actions arising from incidents/accidents were implemented. Information gathered is regularly shared at monthly meetings with incidents/accidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Results of incident/accident data is benchmarked nationally with other Oceania facilities and trends are analysed. Incidents/accidents are also discussed at quarterly regional cluster meetings. Specific learnings and results from incidents/accidents inform quality improvement processes and are regularly shared at health and safety and staff meetings.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p> | FA | Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include reference checks; a signed employment agreement; position specific job description; police vetting; and identification verification. An appraisal schedule is in place and all staff files reviewed evidenced a current performance appraisal. |

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| <p>accordance with good employment practice and meet the requirements of legislation.</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.</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. Interviews confirmed that new staff are supported and buddied into their new roles.</p> <p>The organisation has implemented the Oceania documented role specific mandatory annual education and training modules. Education session attendance records evidenced that ongoing education is provided. This includes dementia/depression and delirium training for all staff providing clinical care. There are systems and processes in place to ensure that all staff complete their required training and competencies. Training records evidenced that staff have undertaken a minimum of eight hours of relevant training.</p> <p>Seven of nine RNs have completed interRAI assessments training and competencies and the remaining two are booked to undertake training in the first half of 2019. Annual competencies are completed by care staff, for example: fire training; infection control; hoist use; restraint; medication management; and wound management.</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>There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Rosters sighted reflected that staffing levels meet resident acuity and bed occupancy.</p> <p>Rosters are available to staff at least two weeks in advance and staffing levels are reviewed to accommodate anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents.</p> <p>There are sufficient RNs and health care assistants (HCA), available to safely maintain the rosters for the provision of care, to accommodate increases in workloads and acuity of residents such as additional hospital level residents. The facility is spread over two main wings each with a central court yard. One wing accommodates a secure dementia unit, with seven beds. The remaining rooms accommodate a mix of rest home and hospital level residents. Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract.</p> <p>There are 42 staff, including: the management team; administration; clinical staff; diversional therapist; activities coordinator; and household staff. Household staff include cleaners, laundry staff and kitchen staff who provide services seven day a week. A review of rosters demonstrated that there is at least one RN on each shift and there is one RN rostered on call. There is one HCA on duty each shift in the dementia unit. In addition, HCA cover in the rest home and hospital includes five HCAs in the morning shift, four in the afternoon and one at night. Interview with the BCM identified that a review of completed timesheets had</p> |

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| | | <p>indicated that additional hours were regularly required to cover night shifts and as a result additional HCA hours will now be rostered on the night shift. The BCM is also available on call after hours.</p> <p>Observation of service delivery confirmed that residents' 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 are busy but have sufficient time to complete their scheduled tasks and resident cares.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>Residents' records are maintained in hardcopy and electronically. Residents' information, including progress notes, are legible and entered into the resident's record in an accurate and timely manner, identifying the name and designation of the person making the entry. Residents' progress notes detailing resident response to service provision are completed whenever there is a change in a resident's condition and at least once every morning and afternoon shift for hospital level and dementia care residents and three time per week for rest home level residents.</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of obligations and procedures for maintaining confidentiality of resident information. Resident care and support information can be accessed in a timely manner and when not in use is protected from unauthorised access by being locked in a cabinet in the nurses' station. Archived records are securely stored and easily retrievable. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the resident and/or the resident's family where applicable.</p> <p>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel only.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been</p> | FA | <p>Residents' entry into the service is facilitated in a timely and respectful manner. Pre-admission packs are provided for families and residents prior to admission. Admission agreements were signed and dated. The facility requires all residents to have Needs Assessment and Service Coordination Service (NASC) assessments prior to admission to ensure they are able to meet the resident's needs. If residents are directly admitted from Waikato District Health Board, the assessment is completed by authorised personnel.</p> <p>The RNs admit new residents into the facility and RNs are responsible for completing all assessments. This was confirmed at interview. Evidence of the completed admission records were sighted. The RNs receive hand-over from the transferring agency, for example, the hospital or NASC and utilise this information when undertaking the initial assessment. The organisation seeks update information from the NASC or the general</p> |

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| <p>identified.</p> | | <p>practitioner (GP) for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Residents records reviewed contained all demographic details, service agreements and family contact details in accordance with contractual requirements. A copy of the enduring power of attorney (EPOA) is established and obtained for residents in the dementia service on admission.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | <p>FA</p> | <p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented procedures to ensure exit, discharge or transfer is undertaken in a timely and safe manner.</p> <p>The service uses the DHB 'yellow envelope' system to facilitate the transfer of residents to and from acute care services. There is open communication between services and appropriate information is provided for ongoing management of the resident.</p> <p>The CM reported that they include copies of the resident's records, including GP visits, medication record, current PCCPs, any up and coming hospital appointments and other medical alerts when a resident is transferred to another health provider.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>Medicine management policies and procedures are implemented and include processes for safe and appropriate prescribing, dispensing and administration of medicines. The treatment room is accessible by the relevant personnel and was observed to be free from heat, moisture and light, with medicines stored in original dispensed packs and folders. Two medication trollies were available and when not in use were stored in the locked treatment room. An electronic medicine system was being utilised. The electronic records were reviewed and contained the required documentation inclusive of prescribing and dated photo identification. All entries were dated and allergies/sensitivities were recorded. The three-monthly GP reviews were dated. Evidence of medication reconciliation was observed in the resident's records reviewed.</p> <p>The process for drug management was verified and confirmed stock checks were completed in the required timeframes. Documentation evidenced medication management requirements are met. Any discontinued or expired medicines are returned to the contracted pharmacy. Sharps bins were sighted as part to the infection prevention and control protocols.</p> <p>Medication administration was observed. The two staff members checked the identification of the residents, completed crosschecks of the medicines in the blister packs and then signed off electronically after the medicines were administered. A safe process was observed.</p> |

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| | | <p>Education in medicine management is conducted. Staff authorised to administer or to check medications complete medication competencies and annual competencies were reviewed.</p> <p>Self-administration of medicine policies and procedures are in place and sighted. There were no residents who self-administered their own medication at the 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 service delivery.</p> | FA | <p>The residents' individual food, fluids and nutritional needs are met. Residents are provided with a well-balanced diet which meets their cultural and nutritional requirements. The meals are prepared and cooked on-site. The four weekly summer menu plans were reviewed by the organisation's dietitian in September 2018. The menu review is based on the Ministry of Health nutritional guidelines for the older people in long-term residential care. A dietary assessment is completed by the RNs on admission. This information is shared with the kitchen staff to ensure all needs, food allergies or sensitivities, likes, dislikes and special diets are catered for. The facility provides modified diets to meet the dietary needs of the residents.</p> <p>A whiteboard was visible in the kitchen which contain important reminders about meals, beverages and modified diets as well as food preferences of residents.</p> <p>The kitchen manager has been in their role for approximately 20 years and previously worked in a hospital kitchen. The kitchen manager works four days a week and is supported in the kitchen by a kitchen hand. A relief cook covers the additional days of the week. The kitchen manager is responsible for all ordering of supplies. The kitchen manager interviewed confirmed documentation of kitchen routines, ordering of supplies, checking in food stuffs when delivered and the cleaning schedules were reviewed and implemented.</p> <p>Nutrition and safe food management policies define the requirements of all aspects of food safety. Labels and dates on all containers and records of food temperature monitoring is maintained. The chiller, fridges and freezer temperatures are monitored. The staff have current food handling certificates.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. The service has a food control plan with an expiry in March 2019 which is displayed.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their</p> | FA | <p>There is a documented process for the management of declining entry to services. Records of enquiry are maintained and in the event of decline, information is given regarding alternative services and the reason for declining services.</p> <p>The administrator often manages the initial calls from prospective residents/families. The CM assesses the suitability of residents and used an enquiry form with appropriate questions regarding the specific needs and abilities of the resident. When residents are not suitable for placement, support is provided to find an</p> |

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| family/whānau is managed by the organisation, where appropriate. | | appropriate care alternative. Management interviews and documentation reviewed demonstrated when a resident's needs change a referral for reassessment to the NASC is made and a new placement is found in consultation with the family/whānau, when necessary. There is a clause in the access agreement related to when a resident's placement can be terminated. |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>The resident's needs, support requirements and preferences are collected and recorded within required timeframes. The RNs or the CM complete a variety of risk assessment tools on admission. Additional assessments were sighted in the resident's records reviewed including, for example, falls risk assessment and subsequent management plan, medical assessment completed by the GP and a recreational assessment completed by the activities coordinator.</p> <p>The interRAI assessments and re-assessments are completed by the RNs. All interRAI assessments are current and the interRAI status report was reviewed.</p> <p>The records reviewed evidenced baseline recordings for weight management and vital signs with monthly monitoring or more often if required. Staff interviews confirmed that the families were involved in the assessment and review processes. If the family are contacted this is recorded on the progress records and the family communication record sheet. The outcomes of the assessments are used in creating an initial care plan, the PCCP and a recreational plan for each individual resident.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>The PCCPs reviewed were resident focused, integrated and promoted continuity of service delivery. An initial plan of care is developed on admission while the PCCPs are developed within three weeks of admission The facility uses an integrated document system where the GP, allied services, the RNs, activities coordinator/diversional therapist, and other visiting health providers write their own care notes in the resident's record.</p> <p>The resident records reviewed had sections, separating key information for ease of reference. Interventions sighted were consistent with the assessed needs and best practice.</p> <p>Goals documented were realistic, achievable and clearly documented interventions. Short-term are developed and implemented, for example, for wound care, skin tears, weight loss and post falls.</p> <p>Residents, families and an EPOA representative interviewed reported participation in the development and ongoing evaluation of care plans.</p> |
| Standard 1.3.6: Service | FA | Residents receive adequate and appropriate services meeting their assessed needs and desired outcomes. In |

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| <p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | | <p>records reviewed interventions were documented for each goal in the PCCPs. Other considerations like pain management, dietary needs, likes and dislikes, appropriate footwear, walking and hearing aids were included in the PCCPs. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. There are appropriate and adequate supplies available for continence and wound care management.</p> <p>Interview with the GP confirmed clinical interventions were effective and appropriate. Review of records indicated that interventions documented by allied health providers were consistent and were included in the PCCP (eg, the dietitian, NASC and other health visitors).</p> <p>Resident and family involvement in the development of goals and review of care plans is encouraged. InterRAI assessment are discussed with the resident and family as able. Multidisciplinary team meetings are conducted by the RNs who discuss and review the PCCP with input of the activities team, the GP and the pharmacist as needed and make changes as required. All resident records reviewed during the on-site audit were signed by either the resident, EPOA or by their families.</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 activities programmes reviewed confirmed that independence is encouraged and choices are offered to residents. The activities coordinator and diversional therapist (DT) plan the recreational programme for the rest home and hospital. A separate 24 hour/7 days a week activities plan is developed and implemented for the dementia service. This activities team were provided with time to maintain the required records and planning.</p> <p>The programme was displayed in the facility and the residents receive a copy of the weekly activities. The activities programme reviewed is signed off by the DT. A range of activities are provided and include physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. During the onsite visit, activities observed included residents listening to music, exercises, craft activities and one-on-one activities. Outings into the community are encouraged and enjoyed by the residents interviewed. Entertainment is provided on a regular basis.</p> <p>There were two residents under 65 years of age and each have their own YPD social and recreational/care plan with goals which are signed off by the DT. A Monday to Sunday plan was sighted with times of day and activities planned documented inclusive of activities in the community and specific activities of choice.</p> <p>Residents' and family confirmed they were satisfied with the activities programme. Feedback is sought with the annual satisfaction surveys and at resident' meetings.</p> <p>Resident records reviewed demonstrated that review of activity plans were completed every six months as part of the multidisciplinary review or when the condition of the resident changes. All resident records reviewed during the on-site audit had current activity assessments in place.</p> |

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| | | Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes anytime of the 24-hour period. Resources are available in the unit for staff to utilise. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress records. If any change is noted, it is reported to the RN. The progress records reflect daily responses to interventions and treatments. The resident records evidenced the six-monthly re-assessment interRAI reviews had been completed in conjunction with the formal care plan review process. Clinical reviews were documented in the multidisciplinary review records which included input from the GP, RNs and HCAs, activities coordinator and members of the allied health team. Short-term care plans evidence review and evaluation of progress as clinically indicated, including for example, for wounds, infections, and post falls. When necessary and for unresolved problems these are transferred to the PCCP. Residents and families interviewed confirmed involvement in the evaluation of progress and resulting changes. |
| 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 choice/needs. | FA | The CM interviewed stated that residents are supported in accessing or in referral to other health and disability providers. The RNs refer residents for further management to the GP, dietitian, physiotherapist, mental health services and NASC as needed. The GP confirmed involvement in the referral process. The service follows a formal referral process to ensure continuity of service delivery. The review of resident records included evidence of recent referrals to the NASC and to specialists. Some residents had been referred to Tokaroa Hospital or Waikato Hospital. Copies of referrals are kept in each individual resident's record. Documentation and interviews confirmed the resident and the family are kept informed of the referral process. Any acute/urgent referrals are attended to immediately such as the GP attending the resident and/or direct transfer to Waikato District Health Board. Documentation evidenced the referral and transfer processes are followed by staff when this is required. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances | FA | Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling and disposal of and collection of waste. The hazard register is available and current. |

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| <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | | <p>Current material safety data posters are available and accessible to staff in relevant places in the facility.</p> <p>Staff receive training and education in waste management as a component of the mandatory training.</p> <p>Interviews and observations confirmed that there is sufficient personal protective clothing and equipment provided, such as aprons, gloves and masks. Interviews confirmed that the use of personal protective equipment is appropriate to the recognised risks. Observation confirmed that personal protective equipment such as aprons was used in high-risk areas.</p> <p>At the time of the audit the facility's unoccupied rooms and other areas were in the process of refurbishment. Processes were in place, such as cordoning off the respective areas to restrict access and screening, to ensure that any potential hazards to residents, staff or visitors were addressed.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>PA Low</p> | <p>A current building warrant of fitness is displayed in the entrance to the facility.</p> <p>A maintenance schedule is in place and implemented, however, not all maintenance requests had been actioned in a timely manner.</p> <p>Staff interviews and visual inspection confirmed there is adequate equipment to support care, including care for residents with disabilities. The facility has an annual test and tag programme and this is up to date, with evidence of checking and calibration of biomedical equipment. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained. Inspection confirmed the van has a current registration and warrant of fitness, first aid kit, extinguisher and functioning hoist.</p> <p>Hot water temperatures are monitored monthly and were noted to be maintained within recommended temperature ranges up until the day of the audit. A review of temperature assays and an interview with the maintenance person identified that on the day of the audit hot water assays had been completed and many were noted to be above 45 degrees Celsius. Interview identified that this was potentially as a consequence of the external roof temperature on that day overheating hot water tanks. It was confirmed that where hot water temperatures were above the recommended safe temperature, immediate action was taken to prevent harm to residents, water temperatures were being reduced and ongoing rechecking of the temperatures would occur to ensure a safe temperature is maintained.</p> <p>All resident areas can be accessed with mobility aides. These include internal artificial grassed courtyards; external grassed areas; and outdoor seating and shade that are able to be accessed freely by residents and their visitors. Observation and residents and family interviews confirmed that residents can move freely around the facility and that the accommodation meets their needs.</p> |

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| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | <p>FA</p> | <p>There are sufficient numbers of accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility. There are 14 rooms that have full ensuite facilities and the remainder access shared toilet and bathroom facilities.</p> <p>Communal toilets have a system to indicate vacancy and have sufficient disability access. A visitor toilet is conveniently located near the entrance to the facility. All shower and toilet facilities have call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence.</p> <p>Residents were observed being supported to access communal showers in a manner that was respectful and preserved resident dignity.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | <p>FA</p> | <p>Residents have their own room and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Resident interviews confirmed that there was sufficient space to accommodate: personal items; furniture; equipment; and staff as required.</p> <p>Residents and their families are able to personalise their rooms. Residents' rooms viewed were personalised with their own furniture. Furniture in residents' rooms includes residents' own personal pieces and memorabilia; is appropriate to the setting; and is arranged in a manner that enables residents to mobilise freely.</p> <p>There are designated areas to store equipment such as: hoists; commodes; wheel chairs; and walking frames safely and tidily.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | <p>FA</p> | <p>There is a main lounge with seating and a view of the garden and two smaller lounges with a view of an internal courtyard. The two internal courtyards and external areas have seating and shade. The main lounge and dining room are in one wing of the facility, adjoining the kitchen. In addition, there are two smaller dining rooms including one in the dementia unit.</p> <p>All areas can be easily accessed by residents and staff. There are sufficient areas for residents to access with their visitors if they wish. This include places where YPD residents can find privacy. Observation and residents and family interviews confirmed that residents can move freely around the facility and that the accommodation meets their needs.</p> <p>The lounges are used for activities.</p> |

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| | | Residents were observed to have their meals with other residents in the communal dining rooms, however, can choose to have their meals in their room if they wish. |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | FA | <p>Facility laundry, including residents' personal clothing, is completed on site. Colour coded, covered laundry trolleys and bags were observed to be used for transport. There is clear delineation and observation of clean and dirty areas in the laundry area. Residents and family members stated that the laundry standard met their requirements. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen. There is one laundry staff member on duty seven days a week. Health care assistants undertake laundry duties in evenings.</p> <p>There are two cleaners on duty each day, seven days a week and cleaning duties and procedures are clearly documented, to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaners store chemicals on a trolley when cleaning and were observed keeping the trolley with them at all times.</p> <p>Interview and observation confirmed that on occasions household staff have more than one role and this can include a combination of kitchen, cleaning and laundry duties. Interviews confirmed that there is clear definitions and separation of, the roles of kitchen; cleaning; and laundry.</p> <p>A sluice room is available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility with alcohol gels in various locations.</p> <p>The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Resident and family interviews and observation noted the facility to be clean and tidy.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | FA | <p>Staff files and training records demonstrated that orientation and annual training includes emergency and disaster procedures and fire safety. An approved fire evacuation plan was sighted. Staff interviews and documentation confirmed that fire drills are conducted at least six monthly. There is a monitored fire alarm; a sprinkler system installed throughout the facility; and exit signage displayed. Training records demonstrate that relevant staff have undertaken fire warden training. The most senior staff member on duty is the nominated fire warden for each shift.</p> <p>The staff competency register evidenced that all RNs have current first aid and cardio pulmonary resuscitation certificates. There is at least one and up to three staff members rostered on each shift with a current first aid certificate.</p> |

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| | | <p>There are sufficient supplies to sustain staff and residents in an emergency situation including alternative energy and utility sources that are available in the event of the main supplies failing. These include arrangements for the supply of an emergency generator; gas cylinders; a barbeque and gas bottles; lighting; sufficient food, water, and continence supplies. The service's emergency plan includes considerations of all levels of resident need, including YPD residents.</p> <p>There are call bells to summon assistance in all resident rooms and bathrooms. Where there is a sensor mat in the room, this connects to the room's call bell system. Call bells are checked monthly by the maintenance person. Observation on the days of the audit and resident and family interviews confirmed that call bells are answered promptly.</p> <p>There are security systems in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building and the facility being locked in the evenings and night time with restricted entry afterhours.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All residents' rooms and communal areas accessed by residents have safe ventilation and sufficient external windows providing natural light. Some have ranch slider doors providing access to external areas. On the day of the audit external temperatures were noted to be in excess of 30 degrees Celsius. Fans and open doors provided cooling to resident areas. The internal facility environment was noted to be maintained at a satisfactory temperature for residents. Some areas had reverse cycle air cooling systems (heat pumps). There is underfloor water heating system for heating in the winter.</p> <p>There are systems in place to obtain feedback on the comfort and temperature of the environment. Resident and family interviews confirmed that the environment was maintained at a comfortable temperature. There are opportunities for residents and family to provide feedback on the temperature of the facility at resident meetings.</p> <p>There are designated shaded external smoking areas and steps in place to ensure that smoking does not impact on other residents or staff.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and</p> | FA | <p>The responsibility for infection control is clearly defined and there is clear lines of accountability for infection control matters in the facility. A senior registered nurse is the infection control nurse (ICN). The ICN has a current job description and has been in this role since October 2018.</p> <p>The infection prevention and control programme is implemented to minimise the risk of infection to resident, staff and visitors. The programme is guided by the infection control manual. The programme is reviewed annually by the support office team. Infection control matters, including surveillance are reported monthly to</p> |

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| visitors. This shall be appropriate to the size and scope of the service. | | <p>the CM and BCM. Infection control is on the monthly quality and staff meeting agenda.</p> <p>Hand washing signage was observed around the facility to remind staff and residents of the importance of proper hand washing. The RN reported that hand-washing audits were completed several times during the year as per the audit schedule reviewed. Pandemic supplies are readily available and checklists were reviewed.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | <p>The infection prevention and control committee is appropriate for the size and nature of this service. The ICN has completed an online infection control course. The ICN confirmed the availability of resources and has four infection control boxes set up in readiness for an outbreak.</p> <p>There is adequate human, physical and information resources to implement the infection control programme and to meet the needs of the organisation.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>The policies and procedures sighted complied with relevant legislation, the infection control standard and current accepted good practice. The policies and procedures are available on the intranet system for staff to access.</p> <p>Care, cleaning, laundry and kitchen staff were observed following policies. Staff interviewed verified knowledge and understanding of infection control principals and infection policies and practices.</p> |
| Standard 3.4: Education | FA | The organisation provides relevant education on infection control to all service providers, support staff and |

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| <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | | <p>residents. The infection control education is provided by either the ICN or by the RNs, who are trained to provide appropriate education.</p> <p>The education provided includes hand washing and standard precautions as additional infection control training. Residents interviewed were aware of the importance of hand washing.</p> <p>The facility maintains regular in-service trainings for infection control including standard precautions, personal protective equipment, cleaning infectious diseases and hand washing. Training records were sighted that are aligned with the Oceania training planner. An outbreak since the previous audit provided a forum for additional education for staff on how the service had responded to this event.</p> <p>Training on the influenza vaccination programme was covered and isolation techniques if and when needed. There are no residents using isolation at the time of this audit. A record of all education provided is maintained.</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> | <p>FA</p> | <p>Surveillance is appropriate to that recommended for long-term aged related care facilities and includes, for example, infections of the urinary tract, wound, soft tissue, pressure injuries, fungal, eye, gastro-intestinal, upper and lower respiratory tract and skin conditions such as scabies. The ICN reviews all reported infections and these are documented. Any new infections and required management plans are discussed at the time of handover between the shifts to ensure early interventions occur.</p> <p>Monthly surveillance data is collated and analysed to identify if any trends, possible causative factors and required actions. Results of the surveillance programme are shared and feedback to staff via regular meetings and at staff handovers. Graphs are produced that identify any trends for the year and comparisons against previous years and this is reported by the ICN and the infection control committee.</p> <p>The infection control surveillance register includes monthly infection logs and antibiotic use. The organisation has an internal benchmarking system. Infections are investigated and appropriate plans of action were sighted in meeting minutes.</p> <p>There has been one gastroenteritis outbreak of infection since the previous audit which involved 17 residents and 3 staff. The outbreak register was completed and public health unit notified. Communication with all stakeholders, including family occurred throughout the outbreak. Victoria Place policies and procedures were followed and the outbreak was fully contained over one week.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that</p> | <p>FA</p> | <p>The restraint minimisation and safe practice policies and procedures provide guidance on the safe use of both restraints and enablers. The restraint coordinator is a senior RN. The restraint coordinator provides support for enabler and restraint management. On interview, the restraint coordinator demonstrated an understanding of</p> |

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| <p>the use of restraint is actively minimised.</p> | | <p>the organisations policies, procedures and the responsibilities for this role. On the day of audit two residents were using a restraint (bedrails) and two resident were using an enabler (bedrails). These were used as the least restrictive and the enabler was used voluntarily at the residents' request.</p> <p>Restraint is used as a last resort when all other alternatives had been explored.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | <p>FA</p> | <p>Policies and procedures are in place and guide staff in restraint processes including approval. The restraint approval group is made up of the restraint coordinator and the GP. The restraint approval group is responsible for the approval of the use of restraints and the restraint processes. Restraint approval group meetings are held two monthly and the minutes were sighted. Staff interviewed and resident records evidenced review of restraint occurs. The two restraints in use had been approved and family involvement was documented in the records reviewed. The use of the restraints and the enablers is documented in the individual PCCPs.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | <p>FA</p> | <p>Assessments for the use of restraint were documented and included the requirements of the standard. Registered nurses complete the assessments. Restraint assessments include identification of restraint related risks; underlying causes for behaviour that requires restraint; existing advance directives; past history of restraint use; history of any abuse and/or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes and possible alternatives to restraint. Evidence of family/EPOA involvement in the decision making was documented on the records in each case reviewed. Families interviewed confirmed their involvement. The GP was interviewed and discussed the role of making the final decision on restraint use and the promotion of safety at all times. Completed assessments were reviewed in the records of residents who were using a restraint.</p> |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | <p>FA</p> | <p>Before implementing the use of restraint the restraint coordinator utilises other means to prevent the resident from incurring injury, for example, the use of low beds, mattresses and sensor mats. Restraint/enabler consents reviewed were signed by the GP, the resident (where applicable) family and the restraint coordinator. Restraint monitoring forms are completed by the HCAs.</p> <p>The records reviewed evidenced that restraints were incorporated in the PCCPs, reviewed three monthly and</p> |

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| | | discussed earlier at the staff meetings. Separate registers are maintained for restraints and enablers. Registers are reviewed at each restraint approval group meeting held two monthly. The registers sighted were up to date and sufficient information was provided to be used as an auditable record. |
| Standard 2.2.4: Evaluation Services evaluate all episodes of restraint. | FA | <p>The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint use, restraint related injuries (if any) and whether the restraint is still required.</p> <p>The resident and the family are involved in the evaluation of the restraints effectiveness and continuity. Family interviewed confirmed their satisfaction with the restraint process. Documentation was sighted in progress records of the resident regarding restraint related matters. Restraint minimisation and safe practices are reviewed two monthly by the approval group and annually by the national restraint authority group as confirmed by meeting minutes sighted. The restraint evaluation documentation covers the requirements of the standard.</p> <p>Education is provided at the annual Oceania mandatory study days and at monthly staff meetings. Training has been provided on restraint policies, use of bed rails and options for bed rail restraint. All staff have completed the restraint competencies.</p> |
| Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint. | FA | <p>The facility demonstrated the monitoring and quality review of their use of restraints which includes the requirements of the standard. The internal audit schedule includes restraint minimisation reviews. The content of the internal audits included the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff knowledge and good practice is also included in the quality reviews. Staff monitor restraint related adverse events while restraint is in use. Any changes to policies, guidelines, education are implemented if indicated. Data reviewed, minutes and interviews with staff including care staff and registered nurses confirmed that the use of restraint has only been used when all alternatives to restraint have been considered, The effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education provided and any feedback is considered from the GP and families.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation. | PA Low | There is a preventative and reactive maintenance schedule and monthly maintenance checks of all areas. The facility had been without a regular maintenance person since August 2018. A new maintenance person had been employed in the week preceding the audit. In the intervening period maintenance had been undertaken by external parties. Staff identify maintenance issues in a maintenance log book. These are reviewed by the maintenance person. Interviews and a review of maintenance requests confirmed awareness of the processes for maintenance requests. However, a review of the maintenance request book identified that not all maintenance requests demonstrated evidence that these have been addressed in a timely manner. | Maintenance requests are not consistently reviewed and prioritised, addressed in a timely manner or signed off when completed. | Ensure that all maintenance requests are reviewed and prioritised, addressed in a timely manner and signed off when completed. 90 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 of this audit.

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End of the report.