

Oceania Care Company Limited - Elmswood Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Oceania Care Company Limited

Premises audited: Elmswood Rest Home

Services audited: Dementia care

Dates of audit: Start date: 12 March 2019 End date: 13 March 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: 33

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Elmswood Rest Home is part of Oceania Healthcare Limited. The facility is certified to provide services for 38 residents. At the time of the audit beds were available for up to 36 residents assessed as requiring dementia level care. There were 33 residents at the 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 family, management, staff, and a nurse practitioner.

There are two areas identified at this audit as requiring improvement relating to cultural needs being reflected in care planning and development of corrective actions from resident incidents.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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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 and is 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.

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 incidents and this is recorded in the resident's file. Residents, family and nurse 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. There have been no complaints to external agencies since the last audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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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 provides operational oversight of the service. The clinical manager is a registered nurse, responsible for clinical management and oversight of services and 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. There is a role specific orientation programme 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

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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Oceania Healthcare Limited - Elmswood Rest Home works with the Needs Assessment and Service Coordination Service to ensure access to appropriate dementia care. Residents receive services from qualified staff. Registered nurses are responsible for completing assessments, including the interRAI assessment, the initial care plan, the short-term care plans for acute conditions and the person centred care plans to guide long-term service delivery.

Transfers to other health services occur as required, with verbal and written handovers and resident and family being participation.

Planned activities are recorded in monthly programmes and overseen by a diversional therapist with help from the assistant activities coordinator. The programmes provide opportunity to residents with a variety of individual and group activities.

There is a medicine management system in place to ensure safe and appropriate processes for prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation. Staff responsible for medicine management have current competencies completed annually. Medicines management training and education occur. There were no residents self-administering medicines at the time of audit.

Menus meet national nutritional guidelines for older people. The service is using the template food plan. Residents' special dietary requirements and needs for assistance during feeding are met. Residents verified their satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness and an approved fire evacuation plan. Essential security systems are in place to ensure resident safety. 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 system 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 services, provided seven days a week by household staff, are monitored. Laundry services are provided offsite.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The Oceania Healthcare Limited restraint minimisation policy and the definitions of restraint and enabler use are aligned with the restraint minimisation and safe practice standards.

The service has an approval process for restraint use in place, which can be activated should a resident require restraint for their own or others' safety.

There were no residents using enablers or restraints during the audit days.

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.
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The service has policies and procedures to guide service delivery. The clinical manager is the infection control nurse. The infection control nurse is responsible for staff education relating to infection control and the surveillance of infections at the facility.

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

Infection surveillance is undertaken, analysed, trended, and results are reported to the support office.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	2	0	0	0
Criteria	0	91	0	2	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>The organisation has 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 mandatory 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, for example options for: shower times, food, clothing and activities; involving family and residents in decision making and ensuring residents are able to practise their own personal values and beliefs (refer to 1.1.6.2).</p> <p>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 resident interviews confirmed they receive information relevant to their needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where</p>	<p>FA</p>	<p>The organisation’s informed consent policy provides the guidelines for staff. It ensures that all residents or their family/EPOA are 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</p>

<p>appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>describes what consent involves and how it may be facilitated, obtained, refused and withdrawn. Cultural considerations are identified such as the involvement of the wider whānau and allowing time for decision making. The policy ensures that staff members adhere to the legal and ethical requirements of informed consent and informed choice for health care services and service provision. It includes 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 CM discusses this with family and the resident 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 included in the information packs provided to family and the resident on admission to the facility. Additional advocacy services brochures are also available at the entrance to the facility. The complaints policy also includes making residents aware of their right to advocacy when making a complaint.</p> <p>Interview with the BCM confirmed that advocacy services can be accessed through the local Nationwide Health and Disability advocate if required. The advocate is invited via email to two monthly facility family meetings.</p> <p>Family 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</p>	<p>FA</p>	<p>Observations and family and staff interviews confirmed that residents may have access to visitors of their choice. There are areas where a resident and family can meet in private. Observations and family interviews confirmed that families are welcome in the facility and were free to visit at any time.</p> <p>Staff and BCM interviews confirmed that residents are free to leave the facility with family to be involved</p>

links with their family/whānau and their community.		in family events and outings. The activities programme and the content of care plans include twice weekly outings in 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 is made available as part of the admission pack. The complaint forms are also available at the entrance to the facility.</p> <p>The BCM is responsible for managing complaints. An up-to-date complaints register is in place that includes the date the complaint is received; the source of the complaint; a description of the complaint; resolution and the date the complaint is signed off. Evidence relating to each lodged complaint is held in the complaints folder and register. Interview with the BCM and a review of complaints indicated that complaints are investigated promptly and issues are resolved in a timely manner.</p> <p>Staff interviews confirmed that family are encouraged to raise any concerns and provide feedback on services and this includes reminding them of the complaints process through family meetings. Family interviews confirmed that they are aware of the complaints process. Family stated that they could raise any issues directly with management and that these are dealt with effectively and efficiently.</p> <p>There have been no complaints to 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) also explains the Code during the admission process to ensure understanding. The pack includes information on the complaints process and advocacy service.</p> <p>The Code and associated information are also available in information brochures which are displayed throughout 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 at the entrance to the facility and within resident areas in the facility.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with</p>	FA	<p>The organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code to ensure that a resident's right to privacy and dignity is upheld.</p> <p>Family and staff interviews and observation confirmed that staff knock on bedroom and bathroom doors prior to entering rooms, ensure that doors and curtains were shut when personal cares were being</p>

<p>respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>provided and residents were suitably attired when taken to bathrooms. Interviews and observation confirmed that conversations of a personal nature were held in private and confidentiality was maintained. Family member interviews confirmed that resident privacy is respected.</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. Staff interviews described how they assisted residents to choose their own clothing to wear each day.</p> <p>Resident files, staff, and family interviews and satisfaction surveys confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented and upheld (refer to 1.1.6.2).</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 mandatory annual training on abuse and neglect. Staff interviews identified that staff are aware of their obligations to report any incidences of suspected abuse. Staff and family interviews confirmed that there was no evidence of abuse or neglect. There were no documented incidents of abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The organisation has a Māori health plan/policy that demonstrates Oceania Healthcare Limited's (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 culturally competent services policy that describes for staff how culturally competent services should be delivered.</p> <p>The BCM interview confirmed that support for staff in providing culturally appropriate care, and for Māori residents and their families, would be sourced if required through the local district health board. Staff receive training in cultural safety and values at orientation and as well as part of the mandatory annual education programme. There were two residents who identified as Māori at the time of audit. Guidelines for staff in terms of interventions to support cultural goals are not recorded in care plans (refer to 1.1.6.2).</p> <p>Staff interviews confirmed awareness of the importance of the involvement of immediate and wider whānau in the delivery of care.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's</p>	<p>PA Low</p>	<p>Staff 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 assessment and care planning</p>

<p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>processes.</p> <p>The information pack advises residents and family/enduring power of attorney (EPOA) to discuss cultural, ethnic and spiritual needs so that the facility can provide care that meets the resident's needs.</p> <p>Information gathered during assessments includes identifying a resident's specific cultural needs, spiritual values, and beliefs. 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 spiritual preferences. This information informs activities that are tailored to meet identified needs and preferences. However, a review of residents' files confirmed that cultural needs, spiritual values and beliefs identified in assessments were not consistently reflected in the residents' care plans.</p> <p>The spirituality and counselling policy ensures access for residents to a chosen spiritual advisor or counsellor where requested. A lay person provides an interdenominational religious service at the facility every two weeks for residents who chose to attend.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There is policy to ensure that 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 their obligation to report any evidence of discrimination, abuse and neglect, harassment and exploitation.</p> <p>There were no documented complaints or incidents recorded since the previous audit relating to any form of discrimination, coercion or harassment.</p> <p>Staff are required to sign and abide by the Oceania code of conduct. Staff mandatory training includes professional boundaries. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Staff and family interviews confirmed that staff maintain appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<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. The facility enters data electronically onto the Oceania database and benchmarking occurs across all Oceania facilities. Staff interviews and monthly meeting minutes identified that the results of benchmarking are made available to, and discussed with,</p>

		<p>staff.</p> <p>Staff 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 on incident forms and in residents' files.</p> <p>Staff and family interviews confirmed that family are included in resident care planning meetings. Two monthly family meetings inform families of facility activities. Meetings are advertised on the facility notice board and in the two-monthly newsletter, as well as the date being confirmed at the preceding meeting. Interviews with the BCM advised that family are also emailed to invite them to the meeting and reminded individually close to the upcoming meeting time. All family are welcome to attend meetings. Meetings also provide an opportunity to provide feedback and make suggestions for improvement as well as raise and discuss issues/concerns with management. Minutes of the family meetings sighted provided evidence that a wide range of subjects are discussed such as, but not limited to: new staff; facility upgrades; activities; survey results; complaints, compliments and infection control. Copies of the meeting minutes are provided to families via email and hard copies are available in the facility reception. Copies of the activities plan and the menu are also available to families and residents.</p> <p>Family interviews confirmed that they felt comfortable in approaching the BCM and staff to discuss services and issues. Family stated in interviews that the BCM addressed concerns and queries promptly and proactively.</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. Interview of the BCM confirmed that a list of interpreter services is available on the Oceania intranet 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</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 management report provides the executive management with progress against identified indicators.</p>

<p>appropriate to the needs of consumers.</p>		<p>Oceania has a documented mission statement, vision and values. These are displayed at the entrance to the facility.</p> <p>There is an overarching Oceania business plan. The facility has a draft budget for 2019 – 2020 that is specific to Elmswood Rest Home that details the facility’s competitor analysis and sets out occupancy projections, budget forecast and expected repairs and maintenance.</p> <p>The facility is managed by a BCM who is supported by a CM. The BCM had been appointed to the permanent BCM role in the week prior to the audit. The BCM has previous experience overseas in human resources with the military and experience in child protection. The BCM has been a relieving BCM at the facility for the last 12 months and has previous experience with Oceania as a health care assistant and administrator. The BCM has undertaken an induction and orientation appropriate to the role.</p> <p>The clinical care at the facility is overseen by the CM. The CM is a registered nurse (RN) who has been in the role for 18 months and has 7 years’ experience as an RN, including previous experience as a clinical nurse leader.</p> <p>The management team is supported in their roles by the Oceania executive and regional teams.</p> <p>The facility is certified to provide dementia level care for up to 38 residents. Of the 38 beds, there were 36 rooms available at the time of the audit with the 2 remaining rooms being used for storage. There were 33 beds occupied at the time of the audit, this included one resident under the age of 65 years of age, under the dementia care contract. The facility has contracts with the district health board (DHB) for the provision of dementia care; respite care and day care.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence of the BCM, a BCM from another Oceania facility located in close proximity would be responsible for the day to day operation of the service. The BCM from the other facility would be supported by the CM, experienced RNs, the regional clinical and quality manager, and the regional operations manager.</p> <p>In the absence of the CM, the BCM from the other facility (who is an RN) with the support and help of RNs and the regional clinical and quality manager will ensure continuity of clinical services.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>PA Low</p>	<p>The facility utilises Oceania’s documented quality and risk management framework that is available to staff to guide service delivery.</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</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. New and revised policies are presented to staff at staff meetings and made available in a file in the staff room. Staff confirmed that they are advised of new and updated policies and sign to confirm that they have read the new or revised policies.</p> <p>The service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators such as complaints; incidents and accidents; surveillance of infections; pressure injuries; falls and medication errors</p> <p>There was evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data provided evidenced that data is being collected and collated with the identification of trends and analysis of data. Corrective action plans are developed, implemented, evaluated and signed off for quality activities such as audit findings and staff incidents. However not all resident incidents had corrective actions consistently developed and implemented. There is communication with staff of any subsequent changes to procedures and practice through meetings.</p> <p>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 that were unable to attend a meeting.</p> <p>Families are notified of updates through the facility's resident meetings. Satisfaction surveys for family on behalf of the resident are completed as part of the internal audit programme. Corrective actions are developed and implemented for issues identified from surveys and these are presented and discussed at family meetings. The March 2019 surveys reviewed evidenced satisfaction with services provided and this was confirmed by family interviews.</p> <p>The organisation has a risk management programme in place that records the management of risks in clinical, environment, human resource and other areas specific to the facility. This is inclusive of facility specific health and safety objectives and targets relating to hazard management; risk management; improving health and safety culture and reducing lost-time injuries. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly.</p> <p>There is a nominated and elected health and safety representative who has received orientation into the role through another facility. Interview confirmed a clear understanding of the obligations of the role and health and safety. Hazard reporting forms and staff interviews confirmed that hazard reporting is actively encouraged. 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 this is reviewed annually. New hazards identified that are not immediately resolved are updated on the</p>
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		hazard register.
<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. Interviews confirmed that these would be reported to the appropriate authority by the Oceania support office. There have been no events since the last audit requiring essential notification.</p> <p>Staff interviews and adverse event forms reviewed confirmed that all staff are encouraged to recognise and report adverse events. Staff interviews confirmed an understanding of the adverse event reporting process and their obligation to documenting all untoward events. Staff records reviewed demonstrated that staff receive education at orientation on the incident/accident reporting process.</p> <p>There is an implemented incident/accident reporting process and incident/accident reporting forms are available in the staff room and on the health and safety notice board. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on an incident/accident form which is signed off by the BCM. There is input from the CM for incidents of a clinical nature. Incident/accident reports selected for review evidenced the resident's family had been notified, an assessment had been conducted and observation completed. There is evidence of a corresponding note in the resident progress notes and notification of the resident's nominated next of kin where appropriate.</p> <p>Corrective actions arising from incidents/accidents were implemented for staff incidents/accidents and resident challenging behaviours (refer to 1.2.3.8). Information gathered is shared at monthly meetings with incidents/accidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Specific learnings and results from incidents/accidents inform quality improvement processes and are regularly shared at quality, health and safety and staff meetings, for example, the use of preventative strategies for frequent-fallers such as bed height, sensor mats, hip protectors, and non-slip socks.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	FA	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions. Staff files reviewed 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.</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>There are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that require them including: RNs; general practitioners (GPs); nurse practitioner (NP); physiotherapist; pharmacists; dietitian and podiatrist.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks, including personal cares. Interviews confirmed that new staff are supported and buddied over their orientation 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. Training records and interviews confirmed that staff have undertaken a minimum of eight hours of relevant training. In addition to 25 staff completing the mandatory training in dementia, depression and delirium, 15 staff have completed the Careerforce dementia specific training.</p> <p>Three RNs, including the CM have completed interRAI assessments training and competencies. There are systems and processes in place to ensure that all staff complete their required training and competencies. Annual competencies are completed by care staff include, 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.</p> <p>Rosters are available to staff one month 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. The facility is divided into two separate areas each with a nurses' station and each with two resident wings.</p> <p>In addition to the CM, who is on duty on the morning shift Monday to Friday, there is one RN on duty on the morning and afternoon shift seven days per week. There are four HCAs on each morning and afternoon shift and three on night shift seven days per week. Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract.</p> <p>There are 27 staff, including: the management team; administration; clinical staff; diversional therapist; activities assistant; and household staff. Household staff include cleaners who provide services seven day a week and kitchen assistants. The BCM and CM are on call after hours. In addition, assistance can be sought from the RN and/or BCM of another Oceania facility located across the road from Elmswood</p>

		<p>Rest Home.</p> <p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed that they have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Residents' records are maintained in hardcopy with electronic medication charts in use. 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 are completed every shift, detailing resident response to service provision.</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of their obligations and the procedures for maintaining confidentiality of resident information. Resident care and support information can be accessed in a timely manner and when not in use is protected from unauthorised access by being locked in a cabinet in a staff office. Archived records are securely stored off-site and easily retrievable the same day if required. 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's family and resident 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 identified.</p>	FA	<p>The entry processes into the service are recorded and implemented. Residents' needs assessments are completed for dementia level of care. Information packs are available for residents and their family with relevant information on services at the facility. Admission agreements define the scope of the service and include contractual requirements. The residents' admission agreements reviewed evidenced sign-off by their enduring power of attorney (EPOA) or their families.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>Exit, discharge or transfer of residents are managed in a planned and coordinated manner. There is evidence of communication between services and the families, as identified in the medical notes. The</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>residents' files evidenced discharge and/or transfer information from the DHB where required.</p> <p>At the time of transition, appropriate information is supplied to the service or individual responsible for the ongoing management of the resident. Referrals were evidenced in the residents' clinical files.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication area included an appropriate and secure medicine dispensing system, free from heat, moisture and light. Medicines are stored in original dispensed packages. The medication room is locked and is only accessible by authorised staff. Drug registers are maintained with RNs completing weekly checks. Six monthly physical stocktakes are undertaken by the pharmacy. The medication fridge temperatures are monitored and recorded.</p> <p>Staff authorised to administer medicines have current competencies completed. A medicines round was observed and seen to meet current legislative requirements and safe practice guidelines. Administration records and specimen signatures are maintained. The service does not use standing orders.</p> <p>Staff members complete education in medicine management. Electronic medicine charts evidenced current residents' photo identification. As required (PRN) medication is identified for individual residents and prescribed in line with legislation, guidelines and good practice. Three monthly medicine reviews are completed and discontinued medicines are dated and signed by the NP. The residents' medicine charts record all residents' medication.</p> <p>At the time of the audit there were no residents who self-administered medicine at the facility.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food service policies and procedures are appropriate to the service setting with a new seasonal menu being introduced six monthly. The provider has an up to date food template control plan, as used throughout Oceania. Food is prepared at The Bayview; an Oceania facility located across the road from Elmswood Rest Home and delivered in hot boxes to the facility's satellite kitchen. The kitchen staff have attended food safety training.</p> <p>Residents' dietary sheets are completed at the service and copies provided to the chef at The Bayview.</p> <p>Personal food preferences of the residents, special diets and modified nutritional requirements are known to the chef and accommodated in the daily meal plan. Lunch time food service was observed and special equipment, to meet residents' nutritional needs, was sighted.</p> <p>Residents' files demonstrated monthly monitoring of individual resident's weight. Interviews with residents stated their satisfaction with the food service. Residents' individual preferences are met and adequate food and fluids are provided.</p>

		All aspects of food procurement, production, preparation, transportation, delivery, and disposal comply with current legislation, and guidelines. Storage of food in the fridge and freezers was in line with best practice.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is a process in place to inform residents and family of the reasons why services had been declined, should this occur. Referral agencies are informed of reasons for decline of entry, when this occurs. Resident and/or their family is referred to more appropriate services in the area, when access to the service is declined. Decline of entry only occurs if the residents' needs are not within the scope of the service or if a bed was not available. The BCM confirmed that no resident has been declined entry since the previous audit. During the onsite audit a resident was transferred to another service as a result of the facility not being able to provide ongoing hospital level of care, as required by the residents' changed condition.</p>
<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>There are processes in place to seek information from a range of sources, for example: resident families; NP; specialists and the referrer. Residents' clinical files showed evidence of an initial nursing assessment on which the initial care plan was based.</p> <p>The assessments are conducted in a safe and appropriate environment, usually the resident's room, including visits from the NP.</p> <p>The interRAI assessment is completed in a timely manner. InterRAI assessments reviewed showed that the use of the interRAI tool triggered the need for additional care requirements of the residents (refer to 1.1.6.2). The service provides appropriate resources and equipment to residents, for example fiddle blankets. Interviews with families confirmed their satisfaction with the care provided.</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>Person centred care plans are in place for residents. Review of the PCCPs showed EPOAs and/or their families sign the PCCPs to evidence of their input into care planning. InterRAI assessments are used to inform the PCCPs (refer to 1.1.6.2).</p> <p>Clinical files showed that the NP reviews residents according to the level of their needs. The residents' file reviewed using tracer methodology showed that where the residents' condition changed, the NP reviewed their medical care monthly and according to their needs. This was confirmed in the medical notes and interview with the NP. Handover was observed during the onsite audit.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Care plans include interventions which are updated when a resident's condition changes. Where STCP were in place, the interventions contributed to meeting the residents' assessed needs and desired outcomes.</p> <p>There is evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were recorded and measurements taken where this was required. Where wounds required additional specialist input, this was initiated.</p> <p>Staff interviews confirmed they have access to the supplies and products they require to meet the needs of the residents. Monthly observations such as weight and blood pressure are completed and are up to date. Residents' family members interviewed expressed satisfaction with the care provided.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Review of the resident files and interviews with the diversional therapist (DT) and the activities coordinator (AC) confirmed the activities programmes meet the needs of the residents. The DT plans, records, implements and evaluates the activities programmes.</p> <p>The activities programme included regular exercises and outings are provided for those residents able to participate. The activity programmes include input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations. The resident under the age of 65 had additional one-on-one activities provided.</p> <p>There are individualised activities care plans in resident' files. Residents' activities attendance records are maintained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluations are carried out by the RNs. Care plans were signed and dated when reviews were undertaken. Evaluations document progress towards meeting the desired outcome. Person centred care plans are reviewed six monthly and signed by the family members as evidence of participation in care planning. Families interviewed confirmed their participation in care plan evaluations. Wound care plans evidenced timely evaluations and review.</p> <p>Activity plans are reviewed at six monthly intervals or when the resident experiences a change in condition. Person centred care plans and STCPs are updated when a resident's condition changes. Interviews verified residents and families are informed of changes in care plans. The NP interview confirmed the staff inform them when a resident's condition requires review. Evaluations of STCPs include sufficient information to inform resident's care.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>There are processes in place to provide choices to families when accessing, or when being referred to, other health and/or disability services. Communication with families are recorded in incident/accident records and confirmed during interviews.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling and disposal of and collecting waste. The hazard register is available and current.</p> <p>Current material safety data posters are available and accessible to staff in relevant places in the facility for example the sluice and cleaning cupboard. The product supplier provides training in the safe use of chemicals.</p> <p>Staff receive training and education in waste management and infection control 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 clothing and equipment is appropriate to the recognised risks. Observation confirmed that personal protective clothing and equipment was used in high-risk areas.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation.</p> <p>A preventative and reactive maintenance schedule is implemented. This includes monthly maintenance checks of all areas and specified equipment such as hoists. Staff identify maintenance issues in a maintenance log book. These are reviewed daily by the maintenance person. Urgent requests are attended to as required. A review of maintenance requests and interviews confirmed staff awareness of the processes for maintenance requests and that repairs were conducted in a timely manner.</p> <p>Staff interviews and visual inspection confirmed there is adequate equipment available to support care.</p>

		<p>The facility has an annual test and tag programme and this is up to date. Evidence of checking and calibration of biomedical equipment was sighted. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained. Van safety checks are undertaken and include for example: tyres; oil; hoist; and first aid kit. Inspection confirmed the van has a current registration, warrant of fitness, first aid kit, extinguisher and functioning hoist. Staff interviews and documentation evidenced that those staff who drive the van are assessed for competency.</p> <p>Hot water temperatures are assayed monthly and are maintained within recommended temperature ranges. A review of temperature assays and an interview with the maintenance person confirmed that where hot water temperatures have been above the recommended safe temperature, action is taken and rechecking of the temperature occurs to ensure a safe temperature is maintained.</p> <p>All resident areas can be accessed with mobility aides. There is a securely fenced grassed area for each of the two resident areas of the facility. In addition, there is a secure external courtyard central to one of the two resident areas of the facility. External areas have outdoor seating and shade and are able to be accessed freely by residents and their visitors. Observation and family interviews confirmed that residents can move freely around the secure areas of the facility and that the accommodation meets their needs.</p>
<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>Sufficient numbers of accessible toilets and showering facilities of appropriate design to meet resident needs are located in each area of the facility. There is a mix of rooms including 1 with a full ensuite; 15 rooms with their own toilet only, and rooms that have 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 located on each of the two resident areas of 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 the resident's 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. Family interviews and observation confirmed that there was sufficient space to accommodate: personal items; furniture; equipment and staff as required.</p> <p>Residents and their families can personalise the resident's room. Furniture in residents' rooms include residents' own personal pieces and memorabilia; is appropriate to the setting and is arranged in a</p>

		<p>manner that enables residents to mobilise freely</p> <p>There are designated areas to store equipment such as wheel chairs, walking frames, commodes and hoists tidily.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a dining room central to the two wings in each of the two resident areas of the facility. There is a sitting room/lounge in each of the two resident areas. All internal communal areas have seating and external views. In addition, external areas provide seating and shade. Areas can be easily accessed by residents, family and staff. Sufficient areas are available for residents to access with their visitors if they wish. Observation and family interviews confirmed that residents can move freely around the facility and that the accommodation meets residents' needs.</p> <p>There is an activities area for storing equipment and resources. A lounge area is used for activities.</p> <p>Residents were observed to have their meals with other residents in the communal dining rooms.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Facility laundry, including residents' personal clothing, is completed off site by another facility. Colour coded, covered laundry trolleys and bags were observed to be used for transport. Household staff interviewed confirmed knowledge of their role including management of any infectious linen. There is clear delineation and observation of clean and dirty areas. Where issues relating to missing residents clothing had been identified corrective actions had been implemented to resolve these. This included recording clothing sent for laundering and checking items on return, and labelling of clothing. Family members and staff interviewed identified that the laundry standard met resident requirements.</p> <p>A cleaner is on duty each day, seven days a week and cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemicals on a trolley when cleaning and is aware of the need to keep the trolley with them at all times. Staff receive training in correct use of cleaning products.</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 externally sourced laundry processes are monitored through the internal audit process with no significant problems identified. Resident and family interviews, resident surveys and observation noted the facility to be clean and tidy.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Staff files and training records 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 sprinkler system installed throughout the facility and exit signage displayed. Training records demonstrated that five staff have undertaken fire/building warden training. There is an overall building fire warden and a nominated fire warden on each shift for each area.</p> <p>The staff competency register evidenced that 22 staff have current first aid certificates. This includes: the CM; RNs; HCAs; and the DT. There are at least two staff members on each shift with a current first aid certificate.</p> <p>The facility has sufficient supplies to sustain staff and residents in an emergency situation. Alternative energy and utility sources are available in the event of the main supplies failing. These include: a barbeques and gas bottles; emergency lighting; sufficient food, water, and continence supplies. Emergency supplies can be supplemented if required from the facility across the road. The service's emergency plan includes considerations of all levels of resident need.</p> <p>Call bells are available to summon assistance in all resident rooms and bathrooms. Call bells are checked monthly by the maintenance person. Observation and family interviews confirmed that call bells are answered promptly.</p> <p>Security systems are 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 with restricted entry, through ringing the doorbell afterhours. Staff receive training in security as part of the annual training programme.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas accessed by residents have safe ventilation and sufficient external windows providing natural light. The facility is heated by wall panel heaters. Fans and open doors provided cooling over summer. The environment in all areas was noted to be maintained at a satisfactory temperature for residents.</p> <p>Systems are in place to obtain feedback on the comfort and temperature of the environment. Observation and family interviews confirmed that the environment was maintained at a comfortable temperature and there were no issues identified with the temperature of the facility.</p> <p>The facility does not have a designated smoking area for residents. At the time of the audit there were no residents who smoked.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection prevention and control policies and procedures manual at Elmswood Rest Home guides and inform staff on infection prevention and control matters.</p> <p>The responsibility for infection control is clearly defined in the infection prevention and control policy that includes the responsibilities of the organisations' infection control committee, consisting of the infection control nurse (ICN) and representatives from other areas of care. There is a signed ICN job description outlining responsibilities for this role. The ICN is the CM who is supported in the role by the BCM and RNs.</p> <p>The internal audit programme includes infection control audits to monitor the implementation of the infection control programme. The programme is clearly defined and reviewed annually.</p> <p>Strategies are in place to prevent exposure of infections to residents, visitors and staff.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICN has access to relevant and current information, appropriate to the size and complexity of this service.</p> <p>Infection control is an agenda item at the facility's meetings. Interview with the ICN confirmed they have access to the infection prevention and control nurse specialist at the DHB.</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</p>	<p>FA</p>	<p>Policies are developed and reviewed regularly in consultation and with input from relevant specialists at the DHB.</p> <p>The infection control manual is up to date. Policies reflect current accepted good practice and reflects relevant legislative requirements.</p> <p>The policies are appropriate to the facility's size and service requirements. The infection control programme forms part of the facility's quality and risk programme.</p>

the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Education for staff in relation to infection control occurs at orientation and induction of new staff.</p> <p>Ongoing training is provided through the facility's annual education and training programme. The ICN is responsible for the training of staff in the facility. The ICN completes training in infection prevention and control through updates at the DHB and e-learning.</p> <p>Residents are encouraged to wash their hands and use hand gels when appropriate. The service includes annual infection control training for residents as part of a resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The ICN is responsible for the surveillance programme.</p> <p>Infection control surveillance occurs monthly with analysis of data and reporting at staff and quality meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infections.</p> <p>Interviews with staff reported they are made aware of infections through handover and verbal feedback from RNs and the ICN. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Elmswood Rest Home uses the Oceania restraint minimisation and safe practice policies, and practices comply with legislative requirements. The restraint policy includes clear definitions of restraint and enablers. Enablers are described in accordance with the Health and Disability Services Standards requirements.</p> <p>Oversight of restraint use at facility is the responsibility of restraint coordinator who is the CM. The responsibilities for this role are defined in the position description which was sighted. The restraint coordinator has completed training in restraint minimisation and restraint management relevant to their role.</p> <p>There were no residents using a restraint at the time of audit. There were no enablers used at this facility, as enabler use is required to be voluntary, and requested by the resident. Residents at Elmswood are not able to make informed decisions and therefore not using enablers.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.6.2</p> <p>The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.</p>	PA Low	Information gathered during assessments includes identifying a resident’s specific cultural needs, spiritual values, and beliefs. This information informs activities that are tailored to meet identified needs and preferences. However, a review of residents’ files evidenced this was not always reflected in the residents’ care plans. Family interviews and surveys confirmed that the services were responsive to individual resident’s cultural and spiritual needs.	Specific cultural needs identified in assessments were not consistently reflected in the residents’ care plans.	<p>Ensure that assessments of ethnic and cultural needs, beliefs and sexuality are reflected in resident care plans.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and</p>	PA Low	Interviews confirmed that staff understood their obligations and the process to complete incident forms for staff and resident incidents. Corrective action plans are developed, implemented, evaluated and signed off for staff incidents and resident incidents relating to challenging behaviours. However, incident forms reviewed demonstrated that six of ten resident incidents did not have corrective actions developed and implemented.	Resident incidents did not have corrective actions consistently developed and	<p>Ensure that a corrective actions plan are:</p> <p>i) developed for all resident incidents/accidents,</p>

implemented.			implemented.	ii) consistently implemented to minimise the risk of further falls or other injury. 90 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.