Oceania Care Company Limited - Holmwood Rest Home

Introduction

This report records the results of a Partial Provisional Audit; 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:	Holmwood Rest Home
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 May 2019 End date: 15 May 2019

Proposed changes to current services (if any): A partial provisional audit was undertaken for the reconfiguration of eight beds into dual purpose occupational right agreement care suites. There is a reduction of the total number of beds from 57 to 50.

Total beds occupied across all premises included in the audit on the first day of the audit: 41

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

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the contractual agreement with the district health board. A partial provisional audit was also undertaken to establish the level of preparedness to provide services in a reconfigured facility with a reduction in total beds from 57 to 50 and 8 occupational right agreement care suites becoming dual purpose. The facility has enough available beds to accommodate all current residents and no resident has been displaced throughout the reconfiguration. Occupancy on the day of the audit was 41.

The audit process included review of policies and procedures; review of resident and staff files; observations and interviews with residents, family, management, staff and a nurse practitioner.

A continuous improvement rating has been awarded for the activities programme, demonstrating achievement beyond the expected full attainment that has benefited the residents and impacted the community.

Consumer rights

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

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights; complaints process and Nationwide Health and Disability Advocacy Service, is provided to residents and their families on admission to the facility. Residents' cultural and spiritual beliefs are identified on admission and there is access to cultural and spiritual support if required.

Residents and families confirmed that their rights are being met, staff are respectful of their needs and communication is appropriate.

There is a documented complaints management system and a register of complaints is maintained. The complaints reviewed were investigated, with documentation completed and stored in the complaints folder.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Oceania Healthcare Limited is the governing body responsible for the services provided at Holmwood Rest Home. The facility implements the organisational business plan which documents the scope, direction, goals, values and mission statement of the facility. The business and care manager responsible for the overall management of the facility is also a registered nurse who is suitably qualified and experienced. The business and care manager is supported by a clinical manager and the regional and executive management team. The clinical manager is a registered nurse, is responsible for clinical management and oversight of services.

There is a quality and risk management system that supports the provision of clinical care and quality improvement. Policies are reviewed nationally. Quality and risk performance is reported through staff and quality improvement meetings at the facility and monthly reports to the national support office allow for benchmarking and the monitoring of service delivery. Benchmarking reports include clinical indicators, incidents/accidents, infections and complaints. An internal audit programme is implemented. Corrective
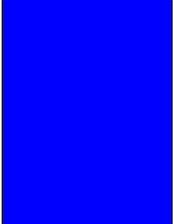
action plans are documented and there is evidence of the resolution of issues when these are identified. There is an electronic database to record risk in which risks and controls are clearly documented.

Adverse events are documented on accident/incident forms and family are notified of any adverse event that occurs.

A review of staff files and training records confirmed that policies and procedures to guide human resource management are implemented. Recruitment and employment practices are in line with legislative requirements and registration with professional bodies is verified annually for all staff who require these. A training plan is implemented, and in-service education is provided for all staff, including mandatory training around clinical service delivery. Staff competency is routinely assessed.

There have been no changes to the staffing structure or systems since the previous audit. Staffing levels met resident needs across the facility. Registered nurses are on duty 24 hours a day, 7 days a week and are supported by adequate levels of care and allied health staff. There are always at least two staff on duty with a current first aid certificate.

Continuum of service delivery

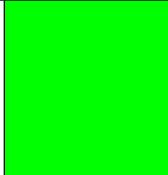| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.

Entry to service is facilitated in a competent, timely and respectful manner. The initial assessment and care plan is utilised as a guide for all staff. The registered nurses complete interRAI assessments within three weeks of admission and any recognised risk assessment tools are used if necessary. The person centred care plan is developed and implemented from the information gathered in assessments. In the files reviewed residents' response to care was evaluated six monthly with relatives notified regarding changes in a resident's health status. The nurse practitioner completes the required medical assessments on admission and regularly thereafter.

Activities are appropriate to the age, needs and culture of the residents and support their interests and strengths. The residents and families interviewed expressed being satisfied with the activities provided by the activities coordinator and assistant.

Medicine management policies and procedures are documented and residents receive medicines in a safe and timely manner. The electronic medication system, processes and practices are in line with the legislation and contractual requirements. Medication electronic records were reviewed. The nurse practitioner/general practitioner complete regular and timely medicine reviews. Reconciliation occurs when a resident is admitted to the facility. There is evidence of pharmacist input. Medication competencies are completed annually for all staff that administer medicines.

The facility utilises four weekly rotating summer and winter menus reviewed by a dietitian. The food service is managed by the kitchen manager and kitchen staff. The service has a food control plan.

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.

There is a current building warrant of fitness. A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes equipment and electrical checks.

The eight occupational right agreement care suites have ensuites. The facility has 22 other rooms with an ensuite bathrooms. Communal bathroom and showering facilities are provided throughout the facility and are easily accessible. Residents' rooms are spacious enough to allow for the assistance of staff and the safe and easy use of mobility aids as required. There are several lounges; a sunroom and external areas providing seating and shade. The facility has a monitored call bell system for residents to summon help, when needed, in a timely manner. Essential security systems are in place to ensure resident safety with six monthly trial evacuations undertaken.

There are documented and implemented policies and procedures for cleaning and waste management. Staff receive training to ensure the safe handling of waste and hazardous substances and are familiar with the requirements for safe handling.

There was evidence sighted of adequate sluice facilities, cleaning and laundry; safe storage of chemicals and equipment; and correct use of protective equipment and clothing. Laundry services are undertaken off site. Cleaning and laundry services are monitored through the internal audit programme.
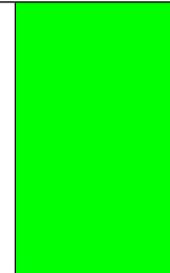
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The facility actively minimises restraint use. The restraint minimisation programme defines the use of restraint and enablers. The restraint register was reviewed and was current at the time of the audit. Five restraints are in use and two enablers.

Policies and procedures comply with the standard for restraint minimisation and safe practice. Risk assessment, documentation, monitoring, managing care and reviews were identified, recorded and implemented. Staff receive adequate training regarding the management of challenging behaviour and restraint use.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. Staff education in infection prevention and control was conducted according to the education and training programme and was recorded in staff files reviewed.

The surveillance data is collected monthly for benchmarking. Appropriate interventions are in place to address infections. There are adequate antibacterial gels and hand washing facilities for staff, visitors and residents. Staff members were able to explain how to manage infections and understood standard precautions.

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	1	49	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	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). Staff receive training in the Code as part of orientation and at least annually as confirmed in records sighted. Education relating to the Code, including the complaints process, is also provided by Health and Disability Advocacy Service and as part of grow, educate and motivate (GEM) study days. In interviews staff confirmed their understanding of the Code and their responsibilities. Staff provided examples on how they implement the Code in to their everyday practice such as maintaining residents' privacy and dignity, encouraging independence and enabling residents to make choices. Care staff were observed interacting with residents in a respectful and supportive manner. Interviews with residents and families and observation verified that services are provided in a manner that upholds resident dignity, with privacy maintained, and individual needs met.
Standard 1.1.10: Informed Consent Consumers and where	FA	There is an informed consent policy and procedure to guide staff in relation to gathering of informed consent. This included guidelines for consent for resuscitation and advance directives. There is an advanced directives and end of life policy to ensure appropriate ethical concepts are upheld in resident

appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.		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. The GPs sign to state the competence of the resident and the resuscitation status selected.

The information pack provided on admission includes information regarding informed consent and the BCM or CM discuss this with residents and their families/EPOA during the admission process to ensure understanding. Staff ensure that residents are aware of treatment and interventions planned for them, and the resident and/or significant others/EPOA are included in the planning of that care. Residents' files identified that informed consent is obtained and that advance directives were completed in accordance with policy.

Staff confirmed their understanding of informed consent processes. |
| Standard 1.1.11: Advocacy And Support

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | There are policies regarding advocacy/support services in place that specify advocacy processes and provide guidance on how to access independent advocates when needed. The role of the Nationwide Health and Disability Advocacy Service is included in the training on the Code which is provided annually to staff.

Information regarding the advocacy service is provided in the information packs provided to residents and family/EPOA on admission to the facility. Additional advocacy services brochures are also available in resident areas in the facility. The complaints policy also includes making residents aware of their right to advocacy when making a complaint. Resident files included information on residents' family/whānau and chosen social networks.

Discussions with residents and families identified that the service provides opportunities for the family or EPOA to be involved in decisions. They confirmed that advocacy support is available to them if required, including information on how to access a Health and Disability advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources

Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy and residents may have visitors of their choice at any time. There are sufficient areas both inside and outside the facility for a resident and family to meet and socialise in private. Observation and interviews confirmed that families were made to feel welcome in the facility. Residents are encouraged to maintain existing community involvement with family and social networks.

Review of resident file documentation evidenced regular outings and external appointments. Resident interviews confirmed that residents are free to leave the facility when they so choose, for example, to attend appointments, social functions and family outings. Families confirmed they could visit at any time and are always made to feel welcome. Residents, including YPD, are encouraged to be involved in |

		community activities and to maintain networks with family and friends.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. The BCM is responsible for managing complaints. Complaint forms are available at the entrance of the facility and provided in facility information packs. A complaints register is in place and the register includes the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved. There were 5 complaints for 2018 and none for 2019. Evidence relating to each lodged complaint is held in the complaints folder and register. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner. There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit. Staff interviews confirmed that when they suspected that a resident was dissatisfied with an aspect of service they would, where appropriate, encourage them to complete a complaint form. Residents and family interviews confirmed that they were aware of a complaints process and stated that complaints are dealt with as soon as they are identified. They were able to describe their rights and advocacy services particularly in relation to the complaints process.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and their families are provided with information about the Code on entry to the facility in the information pack. The pack includes information on the complaints process and advocacy service. The Code and associated information are also available in information brochures which are displayed in resident areas in the facility and available to take away and read in private. The posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English. The business and care manager (BCM) and the clinical manager (CM) interviewed are knowledgeable about the Code and their responsibilities. They discuss the Code with residents and their family during the admission process. The Code is also included on the agenda and discussed at the residents' meetings. Resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. Residents interviewed confirmed they had access to an advocate when needed.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The organisation has a philosophy that promotes dignity, respect and quality of life. There are policies and procedures that align with the requirements of the Privacy Act and Health Information Privacy Code. Health care assistants (HCA) were observed to knock on bedroom doors prior to entering rooms and ensure doors are shut when cares of a personal nature were being provided. Interviews confirmed that conversations of a private or personal nature were held in the resident's room and not in public areas. Residents and families stated that they felt that resident privacy is respected. The organisation has a policy on sexuality and intimacy to ensure that staff understand to respond adequately to a resident's expressions of sexuality. It includes: identifying resident needs; and responding to expressions of sexuality. Resident files reviewed, including a file of a young person with a disability (YPD), confirmed that cultural and/or spiritual values and individual preferences are identified. The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe how to recognise this. There are no documented incidents of abuse or neglect in the business status reports or on the incident/accident forms reviewed in residents' files. Residents, families, staff and the nurse practitioner interviewed confirmed that there was no evidence of abuse or neglect. Staff were aware of the need to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The organisation has a Māori health plan/policy that demonstrates Oceania Healthcare Limited's (Oceania) commitment to respecting the cultural, values and needs of residents identifying as Māori and acknowledges the Treaty of Waitangi. There is also a cultural competency policy that describes for staff how culturally competent services should be delivered. Cultural training for staff is provided as part of the annual training programme. Health care assistants confirmed an understanding of cultural safety in relation to care. The activities coordinator completes cultural assessments on admission and reviews activity plans six-monthly. There were no residents identifying as Māori at the time of audit. A review of residents' files confirmed that specific cultural needs are identified in the residents' care plans.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	Residents and families confirmed that they are involved in the assessment and the care planning processes. Information gathered during assessment includes identifying a resident's specific cultural needs, spiritual values, and beliefs.

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		Review of residents' files demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/EPOA contact details. Documentation provided evidence that appropriate culturally safe practices are implemented and maintained. Residents interviewed confirmed their cultural and spiritual needs are considered and met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility implements the Oceania policies and procedures to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Job descriptions include the responsibilities of position including ethical issues relevant to the role. Staff complete orientation and induction which includes recognition of discrimination, abuse and neglect. Staff training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviews confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination, coercion, harassment or exploitation. Resident and family interviews confirmed that staff maintain appropriate professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Holmwood implements Oceania Healthcare Limited policies and procedures which include current good practice. The policies align with current legislation, guidelines and the Health and Disability Services Standards and ensure safe, current evidence-based practice. Training is provided for all staff by district health board (DHB) specialist educators such as palliative care and wound care as part of the annual in-service education programme. Staff have access to information on good practice provided by governing bodies and specialists in the region. Registered nurses (RNs) attend compulsory education at the DHB and complete the professional development and recognition programme through the DHB. The organisation's quality framework includes an internal audit programme to confirm adherence to policy and good practice. Benchmarking occurs across all the Oceania facilities. Resident and family interviews, resident notes and observation of service delivery confirmed that resident care was based on good practice guidelines.

Standard 1.1.9: Communication	FA	An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. The policy and procedure alerts staff to their responsibility to notify family/EPOA of any accident/incident that occurs.
Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		Clinical files reviewed evidenced timely and open communication with residents and their family members. Communication with family members is recorded in communication records, progress notes and on the incident/accident forms. There is evidence of communication with the general practitioners (GP) and nurse practitioner (NP).
		Families and residents are informed of the range of services provided. Residents sign an admission agreement on entry to service. This provides clear information around what is paid for by the service and by the resident.
		Interviews with residents, including YPD, confirmed they are informed of any changes, are satisfied with how the staff communicate and support their language and communication needs. Family/EPOA are also invited to attend the residents' meetings. A facility newsletter is formulated monthly.
		There is policy that provides guidance for staff on how to access interpreter services and states staff are to access translation and interpreter services for residents if required. At the time of the audit there were no residents who required an interpreter.
Standard 1.2.1: Governance	FA	Holmwood Rest Home is part of the Oceania group with the executive management team providing support to the service. The organisation has values, goals and a mission statement in place. Interview with the BCM confirmed these are communicated to residents, staff and family through posters on the wall, via information in booklets, in staff orientation/training and at resident and staff meetings.
The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		The facility utilises Oceania's overarching business plan. The BCM confirmed the service philosophy and strategic plan reflects a person/family centred approach. The facility 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. Communication between facility management and executive management occurs monthly. The monthly business status report provides the executive management with progress against identified indicators.
		The service has a BCM supported by a CM. The BCM is supported by the regional clinical quality manager who was present during the on-site audit. The BCM is an RN with a current practising certificate who has been in the position for four years and six months. The BCM has previous experience in interRAI education and relevant aged care experience. The clinical care at the facility is overseen by the CM. The CM is an RN and has been in this position for three years and has previous experience in another Oceania facility. Job descriptions and interviews with the BCM and CM confirmed

		their responsibility and reporting lines for their roles.
		Holmwood is currently certified to provide aged related residential care rest home and hospital level care. The facility also holds contracts with the DHB to provide respite care, long-term support for chronic health conditions (LTSCHC), palliative care, care for young people with physical or intellectual disabilities and Accident Compensation Corporation.

There were 41 beds occupied at the time of the audit. Occupancy included 19 residents requiring rest home level care and 22 requiring hospital level care. Included in these numbers were three YPD residents (hospital/physical disability), one resident on LTSCHC (hospital level), one resident on respite (hospital level) contracts and no residents under end of life/palliative care contract.

The facility is certified for 57 beds and submitted a reconfiguration request to HealthCERT during the on-site audit to reduce the total number of beds from 57 to 50. The 50 beds are comprised of 23 hospital beds, 8 rest home beds and 19 dual purpose beds (including 8 proposed occupational right agreement dual purpose care suites). The facility has converted three four-bedded hospital rooms into care suites/dual purpose beds. Each four-bedded hospital room has been converted into two care suites, resulting in six new care suites. Four of the six new care suites are currently occupied by residents at rest home level. In addition, two dual-purpose rooms with existing ensuites have been refurbished to become ORA dual purpose care suites. One of the refurbished dual-purpose rooms was occupied at the time of audit and the other was vacant. The five rest home level residents in the converted and refurbished rooms had ORA in place. Interviews with management and observation verified that the reconfiguration did not require a transition plan and will not impact on current residents.

With the reconfiguration, there will be no changes in key personnel and review of rosters and interviews with management confirm there will be no change required for full time equivalent staff. Key services such as food and hospitality services do not require a change in capacity in order to meet the requirements of the Health and Disability Services Standards. |
| Standard 1.2.2: Service Management

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The service has appropriate systems in place to ensure the day-to-day operations of the service continues should the BCM or the CM be absent. During a temporary absence of the BCM, the CM is responsible for the day to day operation of the service and is supported by the regional clinical and quality manager.

In the absence of the CM, a senior RN with the support and help of the regional clinical and quality manager, ensures continuity of clinical services.

In the advent of a longer term of absence of either the BCM or the CM a temporary appointment may be sourced through Oceania. Support is also available from another Oceania facility in the region. |

		Oceania national support office provides additional assistance when needed.
Standard 1.2.3: Quality And Risk Management Systems

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Holmwood Rest Home uses the Oceania Healthcare Limited quality and risk management framework that is available to staff to guide service delivery. 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. There is communication with all staff of any subsequent changes to procedures and practice through meetings, and for any changes requiring immediate notification via the staff electronic login system. Policy updates are also provided as part of relevant in-service education. Staff interviewed stated they read new or revised policies.

There are monthly meetings including joint quality and staff meetings; health and safety; infection control, restraint and falls; and RN meetings. There are bi-monthly resident meetings which families have the opportunity to attend. Template agendas are used during meetings. Meeting minutes are reviewed by management and provided evidence of discussion and reporting on accident/incidents; hazards; staff wellness programme, health and safety objectives and maintenance. Quality and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. Copies of meeting minutes are available for review in the staff room for staff that were unable to attend a meeting. Residents and family/EPOA are notified of updates through the facility's resident meetings.

Review of the quality improvement data on the day of audit provided evidence the data is being collected, collated, evaluated, and analysed to identify trends. Data is being reported to staff and to the governing body. Staff reported that they are kept informed of quality improvements.

Service delivery is monitored through review of complaints, incidents and accidents, surveillance of infections, pressure injury and soft tissue/wound reviews, and implementation of an internal audit programme. Internal audit schedules and completed audits were reviewed and evidenced corrective action plans were documented when applicable.

Resident/family satisfaction surveys are completed six monthly and results confirmed residents' satisfaction with the levels of care they receive. Resident interviews, including YPD, confirmed their participation in decision making, and having access to technology and the equipment they may need.

Risks are identified and there is a hazard register that identifies health and safety risks, contractual risks, clinical risks and risks associated with human resource management and legislative compliance. The health and safety manual documents health and safety management systems including a health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements, and an emergency plan. There are nominated health and safety representatives and interview confirmed an understanding of the obligations of the role. There was evidence of hazard |

		identification forms completed when a hazard is identified. Review of the current hazard register evidenced this had been reviewed and updated annually or when a new hazard is identified. Hazards are addressed or risks minimised or isolated.
Standard 1.2.4: Adverse Event Reporting 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.	FA	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 and there is evidence of correct and accurate reporting. There has been one essential notification in relation to a grade three pressure injury reported to HealthCERT since the previous audit. Adverse, unplanned or untoward events are recorded on an accident/incident form. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the BCM. Accident/incident reports selected for review had corresponding corrective action plans. There is evidence of open disclosure for recorded events. Staff inform families after adverse events, as confirmed in clinical records and during family and resident interviews. Adverse event reporting occurs nationally through Oceania. Results of accident/incident data is benchmarked nationally with other Oceania facilities and trends are analysed. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared at monthly meetings. Review of documentation, interviews and observation verified there are currently no legislative compliance issues identified that could affect the service such as health and safety, employment or local body issues.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Holmwood Rest Home have human resource management policies and procedures available which are implemented and meet the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and reporting lines. Review of staff files evidenced; employment agreements, reference checks, criminal vetting, drug testing, and completed orientation and competencies. Current copies of annual practising certificates were sighted for staff and contractors that require them to practise. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed. The organisation has a mandatory orientation, ongoing education and training programme with an annual training schedule documented. It requires new staff to demonstrate competency on several tasks, including but not limited to emergency and security systems. Staff complete in-service training

		around a variety of clinical topics. Health care assistants confirmed their role in supporting and buddying new staff.
		Review of staff files and attendance records evidenced orientation, ongoing education (mandatory and ad-hoc) and the required training in palliative care has been completed. Eight RNs, three enrolled nurses (EN) and nine HCAs have completed fundamentals in palliative care or equivalent. All RNs, two ENs and six HCAs have completed a certificate in pain/symptom management or equivalent. Six RNs and three ENs have completed syringe driver training. Five RNs and one EN have completed interRAI assessments training and competencies. There is also one RN in the process of completing this. Annual competencies are completed by all staff, for example: hoist use; infection control; hand washing; wound management; medication management; and moving and handling. All staff have undertaken at least eight hours education and training hours per annum. Registered nurses are supported to attend external training to ensure they are continuing to build upon existing knowledge and skills.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Review of service provider availability such as rostering (including skill mix) and electronic payroll system verified the needs of residents, including those with ORAs are safely met. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. The staffing policy is the foundation for workforce planning. There are 59 staff, including the management team, administration, clinical staff, activities coordinator, maintenance and household staff. A review of rosters demonstrated that there is an RN and an EN on each am and pm shift and an RN on night shift. The BCM and CM are on call after hours, seven days a week. Observation of service delivery confirmed that resident needs were being met in a timely manner. Residents and family interviews stated that staffing is adequate to meet the residents' needs and staff confirm that they have enough time to complete their scheduled tasks and resident cares. The residents who are receiving care in ORA rooms/adjacent to the hospital area have their needs met in accordance with the aged related residential care agreement. With the reconfiguration there is no change required to staffing. There are sufficient RNs and HCAs rostered (sighted), to accommodate fluctuating workloads and acuity of residents such as hospital level residents with the proposed increase in the number of dual purpose beds.
Standard 1.2.9: Consumer Information Management	FA	There are policies and procedures in place for privacy and confidentiality of residents' records. All resident information is maintained in a separate uniquely identifiable record and this includes information

Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		obtained on admission, with input from the resident and/or resident's family/EPOA where applicable. 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 locked office. Archived records are securely stored and easily retrievable. Documents containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Resident records are maintained in hardcopy and information, including progress notes, is entered into the resident record in an accurate and timely manner and identifies the name and designation of the person making the entry. 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. Staff described the procedures for maintaining confidentiality of residents' records.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Resident's entry into the service is facilitated in a timely manner. Pre-admission packs are provided to families and residents prior to admission. Admission agreements were signed and in place in all residents' files reviewed. The facility requires all residents to have Needs Assessment Service Coordination (NASC) assessments prior to admission, to ensure they are able to meet the resident's needs. Interview confirmed the RNs admit new residents into the facility. Evidence of the completed admission records was sighted. The RNs receive handover from the transferring agency for example the DHB and utilise this information in creating the initial person centred care plan (PCCP) for the resident.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The CM reported that they include copies of the resident's records, including NP visits, medication records, current PCCPs, up-and-coming hospital appointments and other medical alerts when a resident is transferred to another health provider.
Standard 1.3.12: Medicine Management Consumers receive medicines in	FA	Medicine management policies and procedures are implemented and include processes for safe and appropriate prescribing, dispensing and administration of medicines. The medication rooms were observed to be free from heat, moisture and light and medicines stored in original dispensed packs and stored in a locked medicines trolley. Medicine records reviewed were electronically maintained. Allergies

| a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | | and sensitivities are recorded or nil known to evidence the resident and/or family have been asked about this during the assessment process. The staff responsible for administration of the medications and the NP/GP have personal access to the electronic system. Resident photo identification was evident. The date of the last medication review was recorded by the NP/GP in records sighted.

All medicines are prescribed by the NP/GP. A medication reconciliation is performed on admission and policy guides the NP/GP with pharmacist involvement as needed. Medication fridges are monitored regularly. Sharps bins were sighted. Unwanted or expired medications are returned and collected by the contracted pharmacy. The pharmacist performs stock checks six monthly.

Medication administration was observed. The staff member checked the identification of the residents, completed cross checks of the medicines against the prescription, administered the medicine and then signed off in line with legislation, protocols and guidelines. The pro re nata (PRN) medicines are monitored by the RNs and the NP. Effectiveness of analgesia given is documented. A bright sticker is used in the progress notes to highlight PRN medication has been administered.

Education in medicine management is conducted. Staff are authorised to administer medications. This required completion of medication competency testing in theory and practice. All staff members responsible for medicines management complete annual competencies.

Self-administration of medicine policies and procedures are in place and sighted. Three residents are self-administering medication during the on-site audit. |
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| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | 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 winter menu is in place and has been reviewed by the organisation's dietitian prior to implementation. The menu plans are based on the nutritional guidelines for older people in long-term residential care. A dietary assessment is completed by the RNs on admission. This information is shared with the kitchen manager to ensure all needs, food allergies, likes, dislikes and special diets are catered for. The facility provides modified texture diets to meet the dietary need of residents if needed.

A white board in the kitchen also contains important reminders about portion sizes, modified diets required and preferences of residents.

The kitchen manager confirmed kitchen routines. Nutrition and safe food management policies define the requirements for all aspects of food safety. A kitchen cleaning schedule is in place and implemented. Labels and dates are on all containers sighted and records of food temperature monitoring are maintained. The chiller, fridges and freezer temperatures are monitored and recorded. The kitchen manager and kitchen staff have completed relevant training and food handling certificates were |

		displayed.
		All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. The service has a food control plan which was verified as current and was displayed.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is a documented process for the management of declines to entry into the facility. Records of enquiry are maintained and in the event of decline information is given regarding alternative services and the reason for declining services. The CM assesses the suitability of residents. When residents are not suitable for placement to the service the family and/or the resident are referred to other facilities depending on their level of needs.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The resident's needs, support requirements and preferences are collected and recorded within required timeframes. The RNs, and/or the ENs overseen by the RNs, complete a variety of risk assessment tools on admission as well as the interRAI assessment at 21 days post admission. The interRAI re-assessments completed six monthly are current and up to date. Additional assessments were sighted in the individual residents' files including the medical assessment completed by the NP and the 'about me' assessment completed by the activities coordinator. The files reviewed evidence baseline recordings for weight management and vital signs with monthly monitoring. Staff interviews confirmed that the families were involved in the assessment and review processes. The outcomes of the assessments are used in creating an initial care plan, the PCCP and a recreational plan for each resident.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The PCCPs reviewed were resident focused, integrated and promoted continuity of service delivery. An initial plan of care is developed on admission while the long-term PCCPs are developed after the interRAI assessment is completed within three weeks post admission. The facility uses an integrated document system where the NP, allied services, the RNs, ENs, activities coordinator, physiotherapist and other visiting health professionals write their care notes. The resident files reviewed had sections for the resident's profile, details, observations, PCCP, monitoring and risk assessments. Goals set were realistic, achievable and clearly documented.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents receive adequate and appropriate services meeting the assessed needs and desired outcomes. In resident files reviewed interventions were documented for each goal in the PCCPs. Interventions sighted were consistent with the assessment needs and best practice. Other considerations, such as pain management, dietary dislikes, appropriate footwear, and walking and hearing aids, were included in the PCCPs. Interview with the NP confirmed clinical interventions were effective and appropriate. Review of files indicated that interventions documented by allied health providers were included in the PCCP. The PCCP evidenced involvement in the resident's care by the dietitian, physiotherapist, wound care specialist, palliative care specialist and the NASC coordinators. Residents and family involvement in the development of goals and review of care plans is encouraged. Multidisciplinary team meetings are conducted by the CM/RNs to discuss and review PCCPs. All resident files reviewed during the on-site audit were signed by either the resident or by their families.
Standard 1.3.7: Planned Activities 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.	CI	The activities programmes reviewed confirmed that independence is encouraged and choices are offered to residents. The activities coordinator is responsible for the programme and is supported by an activities assistant. The activities programme was reviewed, displayed and implemented. The programme is overseen by a diversional therapist from another of the organisation's facilities. The staff plan a range of activities which incorporate education, leisure, cultural and community events for the residents. Both group and 'bedside' activities are provided. The residents' activities assessments are completed within three weeks of the resident's admission to the facility. Information on residents' interests are gathered during an interview with the resident and their family. The activities coordinator develops an activities care plan for each resident that reflects the individual resident's preferred activities. The activities plans are reviewed six monthly at the same time the care plans are reviewed. The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging in a variety of activities and outing. A continuous improvement has been attained for the activities programme in relation to a project that has benefited the residents and has impacted on the community.
Standard 1.3.8: Evaluation	FA	The resident files reviewed showed PCCPs had six monthly reviews completed. Clinical reviews were documented in the multidisciplinary review records which included input for the NP, RNs, HCAs,

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		activities coordinator and members of the allied health team. Daily progress notes are completed by the HCAs, ENs and the RNs. Progress notes reflect daily responses to interventions and treatments. Changes to care are documented. Residents are assisted in working towards goals. Short-term plans are developed for acute problems, for example: infections, wounds, falls and other short-term conditions. Additional reviews include the three monthly medication review by the NP or a GP. The NP interviewed stated the role is overseen by two GPs.
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 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 NP, dietitian, physiotherapist, speech language therapist and mental health services as required. The NP confirmed involvement in the referral processes. The service follows a formal referral process to ensure continuity of service delivery. The review of resident files included evidence of recent external referrals to the physiotherapist and specialists such as the palliative care specialist.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented policies and procedures provide guidelines for staff in the management of waste and hazardous substances. Policies and procedures specify labelling requirements in line with legislation, including the requirements for labels to be clear, legible and free from damage. The hazard register is available and current. Material safety data sheets are available and accessible for staff. Staff receive training and education in safe and appropriate handling of waste and hazardous substances. There is the provision for and availability of personal protective clothing and equipment is provided, such as aprons, gloves and masks that is appropriate to the recognised risks. During a tour of the facility, protective clothing and equipment was observed in high risk areas.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that	FA	A current building warrant of fitness was displayed in the entrance to the facility. The facility is in the process of a reconfiguration with 8 ORA care suites becoming dual purpose. Two proposed ORA care suites in the rest home/dual purpose area have been refurbished only with no structural or electrical modifications. The six care suites/dual purpose rooms in the hospital area which have been converted from four-bedded rooms have sufficient room for mobility access and staff; an ensuite; a kitchenette; heating and external light and ventilation. There is current building consent signed

are fit for their purpose.		off by a registered plumber. There is also an electrical certificate of compliance, including installation of new call bell system which linked to the current call bell system and tested successfully, for all six new care suites. The 8 ORA care suites are fit for purpose.
		The service provides mobility access throughout the facility, meeting requirements of residents including YPD. There are quiet areas throughout the facility for residents and their visitors to meet and there are areas that provide privacy when required. There is access to external paved courtyards, garden areas with outdoor furniture and shade.
		Interview of the maintenance person confirmed there is a planned and reactive maintenance schedule in place. The medical equipment had been checked and calibrated for safe use. The service has a test and tag programme, and this is up to date, with checking and calibrating of clinical equipment annually. Hot water temperatures are monitored monthly and were noted to be maintained within recommended temperature ranges, Interviews with the maintenance person confirmed that where these varied from the recommend range corrective actions were taken immediately to address this.
		Interviews with staff and observation of the facility confirmed there is adequate equipment. The YPD residents confirmed having equipment that met their needs.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are sufficient numbers of accessible toilets provided close to the communal areas. Separate toilets are provided for visitors and staff. All the toilets have a system that indicates if it is engaged or vacant. Bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has 8 care suites with ensuites and 22 other rooms (11 in dual purpose and 11 in hospital) with an ensuite bathroom. Residents in the other rooms access communal facilities. All shower and toilet facilities have call bells and sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence. Residents were observed being supported to access communal toilets and showers in a manner that was respectful and preserved resident dignity.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	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 there is sufficient space to accommodate furniture; equipment and staff as required. The proposed ORA care suites to be used as dual purpose rooms are spacious enough to provide hospital level of care. Residents and their families are encouraged to personalise their rooms. Residents' rooms viewed were personalised with their own furniture; possessions and memorabilia. There are designated areas to store equipment such as mobility aids, wheelchairs and walking frames

		safely and tidily.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The facility has three dining rooms; three lounges; and a television room. Furniture in residents' rooms includes residents' own personal pieces; is appropriate to the setting and is arranged in a manner that enable residents to mobilise freely. The lounge areas can be used for activities. Residents are encouraged to have meals with other residents in communal dining rooms and can choose to have their meals in their room if they wish. There are external areas with seating and shade. All areas are easily accessed by residents and staff. Residents, including YPD, can access areas for privacy, if required.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry except for residents' personal items is undertaken off-site. There are processes in place for daily collection, transportation and delivery of linen. Residents each have their own washing machine for personal laundry. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility. There are cleaners on duty each day, seven days a week and cleaning duties and procedures are clearly documented, to ensure correct cleaning processes occur. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemicals on a trolley whilst cleaning and cleaners are aware of the need to keep the trolley with them at all times. The cleaners have specific guidelines, in the form of a flip-chart, to ensure appropriate cleaning processes. Products are used with training around use of products provided throughout the year. The cleaners confirmed that they had training at least annually. The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Residents and families stated they were satisfied with the laundry and cleaning service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security	FA	The service has documented systems in place for essential, emergency and security services. Registered nurses, HCA, the activities coordinator and the people who drive the van with residents in it, are required to complete first aid training. There are at least two designated staff members on each shift with first aid training. Emergency and security management education is provided at orientation and at the in-service education programme. Staff records sampled provided evidence of current training relating to fire, emergency and security.

situations.		There are security systems in place to ensure the protection and safety of residents, visitors and staff. The facility is locked in the evenings and at night. External doors are checked by the RN at the beginning of the afternoon and night shifts. There is night time security lighting in place. Staff complete security checks at set intervals. Families and residents, including YPD, know the process of alerting staff when in need of access to the facility after hours. There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service. Visitors and contractors are required to sign in and out of visitors' registers, as observed on audit.
		A New Zealand Fire Service notice was sighted advising the fire evacuation scheme has been approved. There is a current fire evacuation plan expiring 20 June 2019 which includes 50 beds and the proposed 8 ORA dual purpose care suites. Interviews and documentation confirmed that fire drills are conducted at least six-monthly. Information in relation to emergency and security situations is readily available/displayed for staff and residents. Emergency equipment is accessible, current and stored appropriately with evidence of emergency lighting, torches, gas and barbeque for cooking, extra food supplies, emergency water and blankets. There is emergency lighting throughout the facility. Interview with the maintenance person confirmed there is access to a generator in the community if required. The RNs on duty are the nominated fire wardens for the facility.
		The services' emergency plan considers the needs of YPD in an emergency.
		Staff files and training records demonstrate that orientation and the annual training programme includes emergency and disaster procedures and fire safety.
		There are call bells to summon assistance in all resident rooms, including the new care suite/dual purpose ORA rooms, toilets and communal areas. Call bells are checked monthly by the maintenance person and the system will highlight in red on the display panel to alert staff if a call bell has not been responded to. Observation on the days of the audit and resident and family interviews confirmed that call bells are answered promptly.
Standard 1.4.8: Natural Light, Ventilation, And Heating

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Policies and procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation and heating. Families and residents confirmed that rooms are maintained at an appropriate temperature. Interviews with the maintenance person confirmed environmental temperatures are monitored quarterly.

The facility is smoke-free for residents and service providers. |

| Standard 3.1: Infection control management

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. | FA | The responsibility of infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The CM is the infection control nurse. The infection control committee is appropriate for the size and nature of this aged residential care facility. Representatives from all areas of service delivery including RN, HCA, kitchen, household (cleaning and laundry) and maintenance representatives were acknowledged. Monthly meeting minutes were reviewed. The CM reported that hand washing audits were completed six monthly.

There is an infection prevention and control programme in place that was last reviewed February 2019. Infection control is part of the monthly staff meeting agenda. When a resident is admitted or presents with an infection, staff send specimens to the laboratory for sensitivity testing if symptomatic. The NP/GP prescribes antibiotics when the result is reviewed. This was confirmed in interview with the NP. The RNs create short-term care plans and review the effectiveness of the prescribed antibiotics when the treatment is completed. The CM collates all the surveillance data for benchmarking. Infections are discussed during the staff meetings and at handover.

There have been no outbreaks of infection since the previous audit. |
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| Standard 3.2: Implementing the infection control programme

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate human, physical and information resources to implement the infection control programme and to meet the needs of the organisation. Hand washing signage was sighted around the facility to remind staff and residents of the importance of handwashing.

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. The CM has completed the Ministry of Health online education in 2018 and attended the Canterbury DHB infection prevention and control services aged residential care and community study day in 2019. |
| Standard 3.3: Policies and procedures

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 | FA | Documented policies and procedures for the prevention and control of infection reflect good practice and relevant legislative requirements and are readily available and implemented at the facility. These policies and procedures are practical, safe and appropriate/suitable for the type of service provided.

The policies and procedures sighted complied with relevant legislation and current accepted good practice. |

Standard 3.4: Education	FA	The organisation provides relevant education on infection control to all service providers, HCAs and residents. The infection control education is provided by either the CM or by external resource speakers at the GEM study days held three time a year. The CM includes handwashing and standard precautions as additional infection training. Residents interviewed were aware of the importance of hand washing.
The organisation provides relevant education on infection control to all service providers, support staff, and consumers.		
Standard 3.5: Surveillance	FA	The CM is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (eg; facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.
Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		Information gathered was clearly documented in the infection log maintained by the CM. Surveillance for infection is carried out in accordance with agreed objectives, priorities and methods that are specified in the infection control programme. Infection control processes are in place and documented.
		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. The surveillance results are discussed at staff meetings.
Standard 2.1.1: Restraint minimisation	FA	The facility actively minimises the use of restraint. Restraints noted to be used in the facility include lap belts and bedrails. At the time of the audit there were five residents using restraints and two using enablers. The files reviewed for restraint enabler use showed enabler use was voluntary and the least restrictive option for the residents. Files reviewed demonstrated that residents who use restraints have risk management plans in place. Restraints were documented in residents' PCCPs. There were no restraint injuries reported. Bedrails have specialised bedrail covers when in use as part of the risk management plan.
Services demonstrate that the use of restraint is actively minimised.		
Standard 2.2.1: Restraint approval and processes	FA	The facility maintains a process for determining approval of all types of restraints used. The CM is the restraint coordinator. The restraint coordinator completes a restraint assessment which is then discussed with the NP/GP prior to commencement of any restraints. The restraint approval group is defined in the restraint minimisation and safety policies and procedures.
Services maintain a process for determining approval of all types		

| the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | | |

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.		In files reviewed the duration of each restraint was documented in the restraint plans of residents. Health care assistants are responsible for monitoring and completing restraint forms when the restraints are in use. Evidence of ongoing education regarding restraint and challenging behaviour was evident in the staff files. Staff members are made aware of the residents using restraints during monthly staff meetings. This was confirmed during staff interviews.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessments include identification of restraint related risks; underlying causes for behaviour that require restraint, existing advanced directives; past history of restraint use; history of abuse and/or trauma the resident may have experienced, culturally safe practices; identification of desired outcomes and possible alternatives to restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Records included assessments, consents, monitoring and evaluation forms. Prior to resorting to 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. Reasons for restraint use are considered and documented in the restraint assessments. Restraint consents reviewed were signed by the NP/GP, the resident (when applicable) family/whānau and the restraint coordinator and the restraint monitoring forms were completed by the HCAs. Files reviewed evidenced that restraints were incorporated in the PCCPs and reviewed three monthly. The service has a documented system in place for restraint use including a restraint register and review evidenced the register was up to date.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint related injuries and whether the restraint is still required. The resident (if able) and family/whānau are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. Restraint minimisation and safe practices are reviewed.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the	FA	The facility demonstrated the monitoring and quality review of their use of restraints. The audit schedule was sighted and included 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 their quality reviews. Staff monitor restraint-related adverse events

monitoring and quality review of their use of restraint.		while using restraint. The restraint minimisation and safe practice policies and procedures were reviewed March 2019 by the National Restraint Authority Group at support office.

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.

No data to display

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, these is a message "no data to display" then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The activities programme at this facility is planned and implemented to develop and maintain strengths, skills, resources and the interests of the residents. The activities coordinator ensures that the content of the programme achieves the goals set in the individual resident's recreational plans and is meaningful to the residents. A project was initiated collaboratively between the activities coordinator and a teacher of a local school who was developing the school's skills programme to build relationships between children and the older persons residing at Holmwood. Community involvement prior to the commencement of the project had included van outings and entertainers visiting on a regular basis. Consent for the project was provided by the BCM. A review of the activities programme was completed and investigated how the programme aligned with the goal of community involvement. Community involvement and having a purpose in life were discussed at the resident activities meeting in January 2018. Students began visiting Holmwood once a week, initially visiting residents in the rest home and the care suites. Following identification that residents were benefiting from the contact with children, this was extended to the hospital. Records have been maintained by the activities coordinator for all visits along with the resident's meeting minutes which have been used to evaluate and evidence how the interaction has benefited the residents. Photographs	A community engagement project was implemented beyond the expected full attainment as a quality improvement initiative for resident involvement with a local school. Evidenced based research was sought that showed that intergenerational learning has benefits both to children and older persons. The residents were

| | | were reviewed of many of the activities. The school has adopted a roster system for the children as it has become such a popular activity with the children. Individual residents interviewed stated they feel relaxed talking with the children and enjoy hearing about the children's lives. Family feedback evidenced support for this project and reported one family member stated they observed a difference when the children had visited and that the resident's mood changed after the visits and they became more talkative with family. Another resident was noted to be more engaged in other activities provided following interaction with the children. The resident's family observed how the children interact with the resident and provided positive feedback. The project has been supported and acknowledged by the community. The increased awareness of this aged care facility within this community has been raised as evidenced in feedback received and reviewed. | consulted and the facility collaborated with a local school to organise student visits once a week.

Feedback from residents and family members evidenced the project has resulted in residents finding a sense of purpose, feeling like they are giving back the community and has had positive impacts on residents' emotional states. The outcomes of this collaboration has exceeded meeting the goals set and benefited the residents, children, family, staff and the school community. |
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End of the report.