

Oceania Care Company Limited - Elmwood Rest Home and Village

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: Elmwood Rest Home and Village

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

Dates of audit: Start date: 13 August 2019 End date: 14 August 2019

Proposed changes to current services (if any): Residents receiving residential disability services at this facility.

Total beds occupied across all premises included in the audit on the first day of the audit: 146

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

Elmwood Rest Home and Village is part of Oceania Healthcare Limited. The facility is certified to provide services for 160 residents. There were 146 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 were areas identified at this audit as requiring improvement relating to wound management and environmental safety.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability 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.		Standards applicable to this service fully attained.
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Oceania Healthcare Limited is the governing body responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned.

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

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

The business and care manager 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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents' records sampled provided evidence that residents have been assessed appropriately prior to admission to the facility by the needs assessment service coordinators. Residents' needs are assessed by the multidisciplinary team on admission. InterRAI assessments, other risk assessments, care plans and evaluations are completed by the registered nurses. Interviews confirmed residents and their families are informed and involved in care planning and the evaluation of care. Handovers, progress notes, diaries, medical and allied health notes guide continuity of care.

The activities programme provides residents with a variety of individual and group activities, including person specific activities for young people with physical disabilities. Community outings are arranged. Entertainers and community groups are invited to participate in the programme.

Medicines are managed using a computerised system and in line with legislation and guidelines. Staff responsible for medication management have attended annual education and completed annual medication competencies. Residents who self-administer medicines had three monthly competencies completed.

All food is cooked on site in a commercial kitchen. Nutritional needs of residents are assessed on admission and additional requirements and/or modified needs are met. The menu is reviewed by a dietitian at organisational level. Residents interviewed confirmed satisfaction with the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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There is a current building warrant of fitness and an approved fire evacuation plan. 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, with options to share a room if preferred. All rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Some rooms have individual ensuite bathrooms and other rooms which share an ensuite between two rooms. There are also communal bathroom and showering facilities throughout the facility, which 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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Policies and procedures comply with the standard for restraint minimisation and safe practice. The restraint minimisation programme defines the use of restraints and enablers. Restraint minimisation is overseen by the clinical manager. The service has a current, up-to-date restraint register. There were six residents using restraint and two residents using enablers during the onsite audit days. Restraint approval, assessment, use, evaluation and monitoring is completed in line with the standard.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme, content and detail are appropriate for the size, complexity and degree of risk associated with the service. The service provides an environment which minimises the risk of infections to residents, staff and visitors.

Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. Staff demonstrated adherence to accepted good practice principles around infection control.

Specialist infection prevention and control advice can be accessed from the district health board; microbiologist, general practitioners and infection control specialists if needed.

The clinical leader is the infection control nurse. Aged residential care specific infection surveillance is undertaken, analysed, trended and results are reported to management and staff. There have been no outbreaks since the last audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	1	1	0	0
Criteria	0	99	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<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.</p> <p>Family and resident interviews and observation confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Observation confirmed that staff are respectful towards residents and their families. Resident and family interviews confirmed they receive information relevant to their needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their</p>	FA	<p>The organisation's implemented informed consent policy provides guidelines for staff. It ensures that all residents or their family/EPOA are informed about the management and care to be</p>

<p>family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>provided in order that the resident may arrive at a reasoned and non-pressured decision about any proposed treatment or procedure. It describes what consent involves and how it may be facilitated, obtained, refused and withdrawn. Cultural considerations are identified such as 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 admission includes information regarding informed consent. This is discussed 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. Four of thirteen residents' files reviewed in the sampling process had current advanced care directive in place. The rest of the resident files had end-of-life care decisions recorded. 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. Advocacy brochures are also available in different languages such as, but not limited to: Samoan; Hindi; Chinese or Niuean if required. 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, when required, can be accessed through the Age Concern; Citizen's Advice Bureau; a hospice and Work and Income.</p> <p>Family interviews verified that the facility provides opportunities for the family to be involved in decisions. Family also confirmed they are aware of the right to advocacy and the advocacy services that are available.</p>

<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Observations, family and staff interviews, and satisfaction survey results confirmed that residents may have access to visitors of their choice. There are areas where a resident, including YPD, and family, can meet in private. Observations, and family and staff interviews confirmed that families are welcome in the facility and were free to visit at any time.</p> <p>Staff, resident and family interviews confirmed that residents, including YPD, are free to leave the facility with family to be involved in local clubs; family events; and outings. The activities programme, and the content of care plans include regular outings in the community are facilitated for all residents, including outings appropriate for YPD, to maintain social networks and attend activities in the community if they so wish.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The 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 Ministry of Health's 'Making a Complaint about your Residential Care' pamphlet that describes the steps to take if a complainant is dissatisfied with the response made to their complaint, is displayed in resident areas in the facility. 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. There have been six complaints logged since the previous audit. 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>Interviews with the BCM, family and residents confirmed that family and residents are encouraged to raise any concerns and provide feedback on services. Interviews with residents and family confirmed that they are aware of the complaints process. They 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>FA</p>	<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 Code is explained to residents and their families during the admission process to ensure understanding. The pack includes a booklet</p>

<p>Consumers are informed of their rights.</p>		<p>outlining the complaints process and advocacy services.</p> <p>The Code and associated information are also available in brochures which are displayed at the reception 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 and throughout resident areas in the facility.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<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. The business and care manager (BCM) is the privacy officer and has undertaken privacy officer training.</p> <p>Interviews with residents, family and staff, and observation confirmed that: staff knock and seek permission before entering a resident rooms and bathrooms, ensure that doors and curtains were shut when personal cares were being provided and residents were suitably attired when taken to communal bathrooms. Interviews and observation confirmed that conversations of a personal nature were held in private and that confidentiality was maintained. Interviews with residents and family 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. Interviews with residents and family confirmed that residents choose their own clothing and accessories to wear each day.</p> <p>Resident files, staff, and family interviews confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented and upheld, for all residents including younger people with disabilities.</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 or neglect. Staff, resident 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</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</p>

<p>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>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>Interview with the BCM confirmed that support for staff in providing culturally appropriate care, and for Māori residents and their families, would be sourced if required through the Counties Manukau District Health Board (CMDHB) or a local Marae. Staff receive training in cultural safety and values at orientation and as well as part of the mandatory annual education programme. There were four residents who identified as Māori at the time of audit. 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 Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Interviews with staff, residents and family 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 processes.</p> <p>The information pack booklet 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 spirituality. This information informs care planning and activities that are tailored to meet identified needs and preferences.</p> <p>The spirituality and counselling policy ensures access for residents to a chosen spiritual advisor or counsellor where requested. The local Anglican church provides an interdenominational service at the facility every Saturday for residents who chose to attend. In addition, weekly communion is offered to Catholic residents who wish to receive it. Local Buddhist and Muslim spiritual support services are available when required.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There is policy to ensure 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</p>

		<p>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. Interviews with residents and family 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>	FA	<p>The facility implements the Oceania policies and procedures which are current, and based on good practice and current legislation and guidelines. The policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice.</p> <p>There are relevant training programmes for all staff.</p> <p>The facility enters data electronically onto the Oceania database and benchmarking occurs across all Oceania facilities. Staff interviews, monthly meeting minutes and staff notice boards reviewed, identified that the results of benchmarking are made available to, and discussed with staff.</p> <p>Interviews with staff, residents and family, review of 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/EPOA contact is recorded on incident forms and in residents' files.</p> <p>Interviews with staff, residents and family confirmed that family are included in resident care planning meetings. Two monthly resident meetings and facility newsletters inform residents and families of facility activities. Resident meetings are advertised on the facility notice board, in the monthly planner of activities and in the two-monthly newsletter. Resident meetings provide an opportunity to give feedback and make suggestions for improvement as well as raise and discuss issues/concerns with management. Meeting minutes sighted provided evidence that a wide range of subjects are discussed such as, but not limited to: new staff; facility changes; meal service; laundry; satisfaction surveys; vaccinations and upcoming events. Copies of the meeting</p>

		<p>minutes are provided to residents and families.</p> <p>Copies of the activities plan and the current menu are also available to families and residents on facility notice boards. Staff and family interviews by the consumer auditor confirmed that the communication needs of all residents, including younger people with disabilities (YPD), were effective and appropriate.</p> <p>The facility newsletter reiterates the BCM's open door policy for residents and family wishing to discuss matters. Interviews with residents and family described being able to raise issues and discuss services comfortably with the BCM. Interviews with residents and family stated that the BCM addressed concerns and queries that were raised promptly and to their satisfaction. Resident satisfaction surveys confirmed that residents were able to meet with the BCM to discuss and issues or concerns.</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 interpreter services when required would be sourced via the CMDHB. Staff represented several ethnicities, reflective of the resident population, including but not limited to: Tongan, Niuean; Samoan; Pilipino; Hindi; Chinese and Māori. At the time of the audit there was one resident who required an interpreter. There were staff available who spoke the resident's language and were able to assist with interpreting services.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The facility is part of the Oceania 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. In addition, there is two weekly monitoring of the clinical indicators by the BCM and the Oceania clinical quality manager.</p> <p>Oceania has a documented mission statement, vision and values. These are available to residents and their families on the Oceania website, in the enquiry pack and in booklets in the facility. Staff receive training in the Oceania mission, vision and values as part of the mandatory training programme.</p> <p>There is an overarching Oceania business plan. In addition, Elmwood has a facility specific business plan for 2019 – 2020 that includes: objectives relating to food service; best practice; clinical leadership and implementing national strategies. The business plans reflect a person/family centred approach.</p>

		<p>The facility is managed by a BCM who is supported by a clinical manager (CM). The BCM had has been in this role for over two years. The BCM has over 10 years previous experience in facility management, including experience in age related care and mental health facilities. The BCM has 18 years' experience as a registered nurse (RN) and has a postgraduate diploma in mental health.</p> <p>The clinical care at the facility is overseen by the CM. The CM is a RN who has been in the role for two years and has three years' previous experience as a RN in another aged care facility, including six months in a CM role. The CM is supported by two clinical leaders (CL) and the regional clinical quality manager. One CL has been in the role of eight months and the other for two months.</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 rest home and hospital level care for up to 160 residents. These include 118 dual purpose beds and 42 rest home beds. There were 146 beds occupied at the time of the audit. This included 60 residents receiving rest home level care, 71 residents at hospital level care and 7 residents who had not been assessed as requiring care and were living independently. In addition, there were 8 residents in the facility with physical disabilities, under the long-term services for people with chronic conditions contract who were under the age of 65. Of these residents, six had been assessed as requiring hospital level of care and two requiring rest home level of care.</p> <p>The facility has contracts with the CMDHB for the provision of: the aged related residential care (ARRC), long-term services for people with chronic conditions; and respite and residential non-acute care.</p> <p>The 118 dual purpose beds include 21 apartment care suites. The apartment care suites are included in the total occupancy numbers with seven occupied by the independent residents, five occupied by residents assessed at rest home level of care and two occupied by residents assessed at hospital level care. Seven apartment care suites were unoccupied.</p> <p>There are 40 residents with occupancy rights agreements (ORA). The ORAs are included in the total occupancy numbers with 7 independent residents; 16 residents assessed as requiring hospital level of care and 17 residents at rest home level of 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</p>	<p>FA</p>	<p>During a temporary absence of the BCM, the CM would perform the BCM role supported by the regional clinical quality manager.</p> <p>In the absence of the CM, a CL or the BCM with the support the regional clinical quality manager</p>

<p>an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>will ensure continuity of clinical services.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The facility utilises Oceania's documented quality and risk management framework that is available to staff to guide service delivery.</p> <p>All policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The Oceania management group reviews all policies with input from relevant personnel. 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; infections; restraint; pressure injuries; falls and medication errors. Clinical indicators are also reported at facility quality meetings; RN meetings and copies are made available to staff in the staff room.</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 inform quality improvements. 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 relevant updates through the facility's resident meetings. Resident meetings provide an opportunity for residents, including YPD, to have input into quality improvements. Satisfaction surveys 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 resident meetings. The 2019 surveys reviewed evidenced satisfaction with services provided and this was confirmed by resident and 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. 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</p>

		<p>confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly.</p> <p>There is an annually nominated and elected health and safety representative. The current representative has been in the role for 10 years and has completed health and safety training to level 4. The representative is supported in the role by the Oceania support office. Interview confirmed a clear and comprehensive 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 hazards are reviewed monthly at health and safety meetings. New hazards identified, that are not immediately resolved, are updated on the hazard register and monitored.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>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. Stage three and unstageable pressure injuries have been reported to HealthCERT since the previous audit (refer to 1.3.3.3). Interviews identified there have been no deaths referred to the coroner since the previous audit.</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. 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. 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</p>

		incidents/accidents inform quality improvement processes and are regularly shared at quality, health and safety and staff meetings.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>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>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 for example: RNs; general practitioners (GP); nurse practitioner (NP); physiotherapist; pharmacists; 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, that is relevant to the services delivered to all residents, including YPD. Education session attendance records evidenced that ongoing education is provided. Training records and interviews confirmed that staff had undertaken a minimum of eight hours of relevant training.</p> <p>Twelve RNs, including the CM and two CLs, 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</p>	FA	<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>There are set rosters for each of the four areas in the facility. One area is utilised as dual purpose, one is utilised for hospital level care residents, one for rest home residents and one includes 25 care suites, which includes the 21 apartment care suites. The rest home area adjoins</p>

<p>service providers.</p>		<p>the care suite area to enable staff to move freely among all resident rooms.</p> <p>Residents, including those in the dual purpose wing at hospital level, have their needs met by sufficient staffing levels. Rosters are confirmed for 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 four separate areas each have a nurses' station.</p> <p>The CM is on duty on the morning shift Monday to Friday, there is at least one CL on the morning shift, seven day per week. The CLs are each responsible for two facility areas. In addition to the CM and CLs, there are six RNs and at least one enrolled nurse (EN) on the morning shift; five RNs on the afternoon shift and two on night shift. There are 19 HCAs on morning, 17 on afternoon shift and 7 on night shift, 7 days per week. All HCAs have completed Careerforce training to level 3 or 4. All HCAs on night shift have current medication competencies and first aid.</p> <p>Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract. There are sufficient RNs and HCAs in each area to ensure that all hospital level residents including those in dual purpose rooms and care suites, receive the appropriate level of care and oversight which meets the requirements of the ARRC agreement. The services for residents with ORA are the same as services for rest home and hospital services for residents under the ARRC contract and other contracts at the facility.</p> <p>The facility will from time to time provide support to residents residing in the retirement village for medical issues. Interviews and roster reviews confirmed that there are sufficient staff remaining in the facility for the short-term absence of an RN attending to village residents.</p> <p>There are 142 staff, including: the management team; administration; clinical staff; diversional therapist; activities staff; and household staff. Household staff include cleaners who provide services seven day a week, a laundry assistant and kitchen staff. The BCM and CM are on call after hours seven days per week.</p> <p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Resident and family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed that whilst they are busy at times, they complete their scheduled tasks and resident cares over rostered shifts.</p>
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<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>	<p>FA</p>	<p>Residents' records are maintained in hardcopy with electronic medication charts in use.</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. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel only.</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. Information entered into residents' progress notes is legible, accurate and entered in a 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>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals.</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>	<p>FA</p>	<p>Needs assessment and service coordination (NASC) assessments are completed for all residents on entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. Young people with disabilities are assessed to confirm the appropriate level of care and the NASC authorisation is held on file.</p> <p>An information pack provided to all residents and their families prior to admission. Residents and family members interviewed stated they had received the information pack. Interviews also confirmed they had received sufficient information prior to and on entry to the service.</p> <p>Review of residents' files confirmed entry to service processes and compliance with entry criteria. Interviews with residents and family and review of records confirmed the admission process was completed by staff in a timely manner.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	<p>FA</p>	<p>There is a policy that describes guidelines for discharge, transfer documentation and follow-up. A record is kept, and a copy is kept on the resident's file. All relevant information is documented</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Interviews with staff and review of documentation confirmed staff reduce risk for residents during transition, transfer, exit or discharge from the facility.</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>There are policies and processes that describe medication management that align with accepted guidelines. Policies document staff responsibilities for each stage of medication management. A computerised medication management system is used at the facility and meets the current legislative requirements and safe practice guidelines.</p> <p>Medicines are delivered in a pre-packed delivery system. Medications are checked against the resident's medication profile on arrival from the pharmacy by a RN.</p> <p>Review of the medication areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The medication refrigerator temperatures are monitored and recorded weekly and were within the recommended temperature range. The service does not store any vaccines. The drug register is maintained and evidenced weekly checks and six-monthly physical stocktakes.</p> <p>The medication rounds observed during lunch evidenced compliance with legislation, protocols and guidelines. Medication management is recorded to a level of detail and communicated to residents in a way that complies with legislation and guidelines. Administration records are maintained, as are specimen signatures. Interviews with RNs confirmed there were no standing orders at time of audit.</p> <p>Staff authorised to administer medicines had current competencies. Staff education in medicine management is provided. The RNs had completed current syringe driver competency and education.</p> <p>Residents' who request to self-administer medicines are provided with secure storage for their medicines. An initial assessment to verify the resident's safety and competency to administer medicines is completed by the GP. Three-monthly competency assessments were recorded for one resident self-administering their medication. Young people with disabilities who are assessed as able, can self-administer their medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and</p>	<p>FA</p>	<p>The chef at the facility had resigned recently before the on-site audit and management is in the process of recruiting another chef. The service employs two cooks who, with the BCM, are responsible for the management of the kitchen, including ordering of food, equipment and</p>

<p>nutritional needs are met where this service is a component of service delivery.</p>		<p>resources. All kitchen staff have current food safety training.</p> <p>There is a current, verified food control plan in place. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines, as verified during the on-site audit. Food is plated and served in the main dining room. The kitchen provides a tray service for residents to dine in their rooms if required.</p> <p>Food, fluid and nutritional needs of residents are in line with recognised nutritional guidelines. There are four-weekly seasonal menus reviewed annually by a dietitian at the organisational level. A nutritional profile is completed for each resident by a RN once the resident is admitted to the service. A copy is provided to the kitchen. Food preferences and cultural considerations are noted. Special diets are considered and catered for. There is specialised crockery such as lip plates, mugs and utensils to promote resident independence with meals. Snacks are available 24 hours a day.</p> <p>Residents and families interviewed reported they are satisfied with the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service has a process in place where access is declined, should this occur. When residents are declined access to the service, residents and their family, the referring agency, GP and/or NP are informed of the decline to entry and of alternative services available. The resident would be declined entry if not within the scope of the service or if a bed was not available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial nursing assessment and the initial care plan is completed within 24 hours of admission. Assessments are recorded, reflecting data from a range of sources, including: the resident; family; GP/NP; and specialists as applicable (refer to 1.3.3.3).</p> <p>Review of wound care documentation evidenced all wounds including skin tears are recorded on short-term care plans (refer to 1.3.3.3). Resident assessments inform care plans. Policies and protocols are in place to ensure continuity of service delivery. Assessment tools are reviewed at least six monthly including but not limited to: falls; dietary; continence; and pain. Residents interviewed confirmed assessments are conducted according to their needs and in a private manner.</p> <p>Interviews with residents and families confirmed their involvement in the assessments.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Person centred care plans are developed with the resident and family/whānau involvement where appropriate. Files sampled had an individualised PCCP. The care plans evidenced service integration with progress notes, activities notes, and medical and allied health professionals' notations.</p> <p>Interviews with residents confirmed they have input into their care planning and review, and that the care provided meets their needs.</p> <p>The PCCPs for YPDs are developed with the resident and includes goals for wellbeing, community participation, meeting their physical and health needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>In residents' files sampled wound care plans, nutrition management, skin integrity management, medical specific plans, pain management and falls prevention plans were evident (refer to 1.3.3.3). Observation charts, weight and neurological observations are recorded. Assessments, monitoring and evaluation around pain were completed and documented. The use of short-term care plans was evident. Care planning includes specific interventions for both long-term and the short-term problems as per assessed needs (refer to 1.3.3.3).</p> <p>Discussions with residents, family and staff confirmed care provided is consistent with the needs of the residents. The RNs and HCAs follow the care plan and report progress against the care plan on each shift at handover. Nursing progress notes record changes. Family communication is recorded in the residents' files.</p> <p>If external nursing or allied health advice is required, the RNs will initiate a referral, for example; to the WNS, physiotherapist or podiatrist (refer to 1.3.3.3). Specialist recommendations are implemented. Medical records document reviews at least monthly or more frequently if needed. The NP spoke positively about the service and described effective communication processes. Residents can choose to retain their own GP/NP.</p> <p>There were sufficient supplies of products and equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p> <p>Residents are assisted in developing and maintaining their links with other services.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	<p>FA</p>	<p>The facility provides activity programmes which reflects the residents' goals, ordinary patterns of life, and includes community activities, including specific opportunities for YPDs to have</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>additional social activities. Young people with disabilities can participate in a range of education, recreation, leisure, cultural and community events consistent with their interests and preferences.</p> <p>Review of files evidenced residents' social history and their preferred activities are identified on admission. The diversional therapist (DT) plans monthly programmes with input from a second DT, and support of an activity assistant.</p> <p>Residents are free to choose whether they wish to participate in the group activities. Residents' participation in a daily exercise programme was evidenced on audit days. Residents are encouraged to maintain links with the community through outings with family and van outings. Birthdays and other special days are celebrated. Residents who prefer to stay in their room can have one-on-one visits including, for example, reading, hand massage and music.</p> <p>Residents' attendance and participation is documented. Outcomes against goals are recorded. Evaluations are completed six-monthly with nursing review and there is evidence of resident and family participation. Resident meetings are conducted bi-monthly and include discussion around activities.</p> <p>The residents and their families reported satisfaction with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>There are monthly reviews by the GP/NP or sooner if required. Person centred care plan reviews are completed six monthly or when the resident's condition changes. There was documented evidence that RN evaluations were current and completed for all care plans sampled. Resident care is evaluated on each shift and reported in the residents' progress notes. Short-term care plans are signed off once resolved or added to the long-term care plan if the problem is ongoing (refer to 1.3.3.3).</p> <p>Interviews verified residents and family/whānau are included and informed of changes in health condition.</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</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. If the need for other non-urgent services are indicated or requested, the GP, NP, RN, or BCM sends a referral to seek specialist service provider assistance from CMDHB (refer to 1.3.3.3). Referral forms and documentation are maintained on resident files.</p> <p>The family/whānau communication records reviewed in the residents' files, confirmed family are kept informed of the referral process.</p>

choice/needs.		
<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>	FA	<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. Training records and staff interviews confirmed that there is regular 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>	PA Low	<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. Staff identify maintenance issues in a defect 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 for all residents. This includes YPD, who have their own personal equipment and input into the purchasing of personal and facility equipment. 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; and first aid kit. Staff interviews, and documentation evidenced that those staff who drive the van are assessed for van driver competency, such as knowledge of routine pre-travel checks of van and equipment.</p> <p>Hot water temperatures are monitored monthly and are maintained within recommended temperature ranges. A review of temperature assays and an interview with the maintenance</p>

		<p>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. However, wall mounted radiator heaters, that a resident could come into contact with, were noticeably hot.</p> <p>All resident areas can be accessed with mobility aides. External areas have outdoor seating and shade and can be accessed freely by residents and their visitors. Observation and resident and family interviews confirmed that residents can move freely around 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>	FA	<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 care suites that have full ensuites; some rooms with ensuites are shared between two rooms; and other rooms that have access shared toilet and bathroom facilities.</p> <p>Communal toilets have a system to indicate vacancy and have disability access. Visitor toilets are located in the main corridor. 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>	FA	<p>There is one room that is shared by a couple and all other residents have their own rooms. Each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Interviews with residents and family 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 manner that enables residents to mobilise freely.</p> <p>There are designated areas and sufficient space to store equipment such as: wheel chairs; walking frames; commodes and hoists, tidily.</p>
Standard 1.4.5: Communal Areas For	FA	There are dining rooms and lounge areas in each of the four main areas of the facility. Between

<p>Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>the dual purpose area and rest home area there are shared communal spaces (e.g the lounge used for occupational therapy) to ensure that rest home level residents have their socialisation needs met. In addition, there is a whānau room situated in the hospital area, for use by residents' families. All internal communal areas have seating and external views. Areas can be easily accessed by residents, family and staff.</p> <p>Sufficient areas are available for residents, including YPD, to access with their visitors or find privacy, if they wish, as well as small nooks throughout the facility with seating for residents to read and relax. Observation and interviews with residents and family 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 spacious lounge area is designated for activities.</p> <p>Residents were observed to have their meals with other residents in the communal dining rooms but could have their meal in their room if they so wished.</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>	<p>FA</p>	<p>Facility laundry, including residents' labelled personal clothing, is completed off site. There is a laundry assistant on each day to unpack, sort and delivery facility and resident laundry. Colour coded, covered laundry trolleys and bags were observed to be used for transport. There is clear delineation and observation of clean and dirty areas. Interviews with residents and families identified that they were satisfied that the laundry standard met their requirements.</p> <p>The facility has seven cleaners on duty each day, Monday to Friday inclusive. There are four cleaners on Saturdays and three on Sundays. 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 observation confirmed that they always keep the trolley with them. Staff receive training in correct use of cleaning products.</p> <p>Sluice rooms are 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. Interviews with staff and review of documentation confirmed that fire drills are conducted at least six monthly. There is a sprinkler system installed throughout the facility and exit signage displayed. There are nominated fire wardens on each shift for each area.</p> <p>The staff competency register evidenced that RNs/ENs staff have completed advance first aid and HCAs have completed basis first aide. There are always staff members rostered in each area with a current first aid certificate.</p> <p>The organisation has an emergency plan that considers the needs of all residents, including YPD. 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; an externally sourced generator; emergency lighting; oxygen; sufficient food; water; and continence supplies. 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 automatically locked in the evenings with restricted entry. All RNs carry cell phones and 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 and some heat pumps (refer to 1.4.2.4). There is a ducted fresh air system.</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 has a designated external smoking area for residents who smoke, that does not impact on other residents or staff.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Oceania Healthcare Limited has an established infection control programme. The infection control programme is reviewed annually with the last review in February 2019. The infection control programme, including its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The programme is linked into the incident reporting system.</p> <p>There was a signed infection control nurse job description outlining responsibilities of the position. The designated infection control nurse (ICN) is a RN/CL. The BCM, regional clinical quality manager, Oceania infection control committee and facility infection control team provide guidance to the ICN. Infection control meeting minutes are available for staff. Internal audits conducted include hand hygiene and infection control practices.</p> <p>Visual information is located throughout the facility for visitors, staff and residents' awareness of infection control procedures to minimise the risk of infection.</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 is responsible for implementing the infection control programme. The ICN indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>Oceania has documented policies and procedures in place that reflect current best practice relating to infection prevention and control. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all</p>	<p>FA</p>	<p>Infection control education for staff starts at orientation and induction of new staff and ongoing training is provided through the organisation's annual education and training programme or at an ad-hoc basis when required. The ICN has completed a postgraduate diploma in infection</p>

<p>service providers, support staff, and consumers.</p>		<p>prevention and control and completes training in infection prevention and control through updates at the district health board and e-learning. The ICN is responsible for the training of staff in the facility. Resident education occurs as part of the daily care and residents are encouraged to wash their hands and use hand gels when appropriate.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Definitions of surveillance and types of infections are clearly defined and documented to guide staff. The surveillance is appropriate for the size and complexity of services provided. Infection control alerts were documented on the individual residents' records reviewed. All staff are required to take responsibility for surveillance activities. Interviews with staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers and progress notes. This was evidenced attending handover and review of the residents' files.</p> <p>The service submits data monthly to Oceania support office where benchmarking is completed. Infections collated monthly include for example: urinary tract; upper respiratory and skin. This data is analysed for trends and reported to the quality, RN and staff meetings. There have been no infection outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enabler are congruent with the definitions in the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, as confirmed at staff and management interviews.</p> <p>The restraint and enabler register is maintained. There were two enablers and six restraints in use on audit days in the form of bed rails and lap-belts.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this</p>	<p>FA</p>	<p>The Oceania clinical and quality team are responsible for approving any form or type of restraint practice used at Oceania facilities nationally.</p> <p>Oversight of restraint use at each individual Oceania facility is the responsibility of the restraint coordinator. The restraint coordinator is the CM. The responsibilities for this role are defined in the position description. The restraint coordinator had completed training in restraint minimisation and restraint management relevant to their role.</p> <p>Restraints are authorised following assessment of the resident. The approval includes</p>

process is made known to service providers and others.		<p>consultation with the multidisciplinary team.</p> <p>Interviews with staff and staff records confirmed that restraint minimisation and safe practice, enabler usage, and prevention and/or de-escalation education training is provided.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The resident records reviewed for restraint use included consent and assessment which meet the criteria as outlined in this standard. The restraint consent forms evidenced consent for restraint is obtained from the GP/NP, restraint coordinator, and/or a family member. Culturally safe practice was maintained throughout restraint use, as evidenced in care planning.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised, and the restraint coordinator described the alternatives to restraints are discussed with staff and family/whānau members. Staff interviewed understood the use of restraints is to be minimised and how to maintain safe use was confirmed.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe as verified in the resident's PCCP and monitoring forms. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month, and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Interviews with staff confirmed evaluations of any restraint are to be completed at three-monthly intervals. The restraints in use at the time of audit had three monthly evaluations completed.</p> <p>The restraint coordinator and RNs maintain communication with families regarding restraint use.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint coordinator reports on restraint management at monthly meetings. Interviews confirmed that the restraint approval process forms part of the medical review. The three-monthly restraint review includes: effectiveness of the restraint; compliance with policy and procedures; adverse events related to restraint use; and the possibilities of discontinuing restraint.</p> <p>Consent forms for restraint included timeframes for daily monitoring. Review of restraint consent, at the time of the on-site audit, showed these monitoring times were recorded.</p> <p>Interviews with staff confirmed that monitoring of restraints is physically taking place according to</p>

		the frequency recorded in the consent record.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>Documentation for all wounds (36 at time of audit, including 10 pressure injuries) was reviewed. Assessment, goals, plan and timeframes for the monitoring, review and management of wounds were documented, however, pressure injuries were not consistently identified or recognised by staff and specialist responses were not always timely.</p> <p>During review of resident clinical folders and tracer methodology of a resident receiving hospital level care, it was found that five pressure injuries were not identified on admission or during daily cares. This resulted in the resident having five necrotic pressure injuries. The facility NP reviewed the resident eight days after the pressure injuries were identified. Review of the wound care folder showed that until the second day of audit there was no specialist input into the care of these pressure injuries, despite several referrals to the WCS. Oceania took steps to ensure the staff member involved in this omission has appropriate oversight, however, there was no evidence of staff being provided with information on how to recognise a pressure injury or staff receiving training on recognising signs and</p>	<p>i) Pressure injuries are not consistently identified/recognised by staff.</p> <p>ii) Referral responses from WCS, the NP/GP and/or other specialists were not followed up in a timely manner.</p>	<p>i) Provide information and training to staff to facilitate early identification/recognition of pressure injuries.</p> <p>ii) Ensure timely referrals to and input from referrals such as WCS, the NP/GP and/or other specialists.</p> <p>60 days</p>

		symptoms of pressure injuries.		
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	<p>Strategies are in place to ensure that hot water temperatures are maintained at safe levels and equipment and the facility are safe for residents. However, testing by the audit team identified the temperature of wall mounted radiator heaters was noticeably hot to touch, and could cause harm should a resident fall against one.</p>	<p>The wall mounted radiator heaters in areas accessed by residents were noticeably hot to touch.</p>	<p>Ensure that strategies are implemented to mitigate against the risk of harm to anyone coming into physical contact with a panel heater.</p> <p>90 days</p>

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.