

# Oceania Care Company Limited - Amberwood Rest Home

---

## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Amberwood Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 18 February 2020      End date: 19 February 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	57

# 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

Amberwood Rest Home is part of Oceania Healthcare Limited. The facility is certified to provide services for 70 residents requiring rest home or hospital level of care. There were 57 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 review of policies and procedures, review of resident and staff files, and observations and interviews with family, management, staff, a general practitioner, and a social worker.

There was one area identified as requiring improvement at this audit relating to a safe environment.

## 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 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. Interviews with residents, family and the general practitioner confirmed that the environment is conducive to communication 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.
---	--	--

Oceania Healthcare Limited is the governing body responsible for the services provided at Amberwood rest home. The mission, vision and values of the organisation are documented and communicated to all concerned.

The business and care manager is a registered nurse and responsible for the overall management of the facility and is supported by the regional operations manager. The clinical manager, supported by the regional clinical quality manager and registered nurses, is responsible for clinical management and oversight of services.

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

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

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 good practice. Staffing levels are adequate across the services.

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

## Continuum of service delivery

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

The organisation works with the needs assessment coordination service to ensure access to the service is effective with all relevant information available, when a resident seeks to access the facility.

The residents' needs are assessed on admission by registered nurses. Residents' initial care plans completed within the required timeframes and short-term care plans for acute conditions are in place where applicable. The residents' files provided evidence of documented residents' needs, goals and outcomes that are reviewed on a regular basis.

Nursing care plan evaluations are documented, resident focused and indicate progress towards meeting the residents' desired outcomes. There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and a family member interviewed reported being informed and involved, and their satisfaction with services.

The activities programme includes a range of activities and involvement with wider community. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

There is a medicine management system in place which complies with legislation, protocols, and guidelines. Staff responsible for medicine management have current medication competencies. The residents self-administering medicines do so according to policy.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. There is a central kitchen and on-site staff that provide the food service. The residents verified satisfaction with meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
--	--	---

There is a current building warrant of fitness and an approved fire evacuation plan. Essential security systems are in place to ensure resident safety. Six-monthly trial evacuations are undertaken.

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

Residents' rooms provide single accommodation and are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has a monitored call bell system for residents to summon help, when needed, in a timely manner.

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

## 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.
---	--	--

Policies and procedures reviewed comply with the standard for restraint minimisation and safe practice. The restraint minimisation programme defines the use of restraints and enablers. The service had no residents using restraint or enablers on audit days.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme, content and detail are suitable for the size, complexity and degree of risk associated with the service. The service delivers an environment which minimises the risk of infections to residents, staff and visitors.

Documentation reviewed evidences 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 compliance with infection control practice principles and policy.

The district health board can be accessed to provide specialist infection prevention and control advice including microbiologist, and infection control specialists if needed. The facility general practitioner confirmed infection control compliance.

The clinical manager is the infection control coordinator. Aged residential care specific infection surveillance is undertaken, analysed, trended and results are reported to management and staff.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	44	0	1	0	0	0
<b>Criteria</b>	0	92	0	1	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: 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 described practices that evidence an understanding of 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 (eg, options for 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>Resident and family interviews, as well as observation, confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff are respectful towards residents and their families and resident interviews confirmed they receive information relevant to their needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where</p>	FA	<p>The organisation’s informed consent policy provides guidelines for staff. 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;</p>

<p>appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>photographs; specific cares; collection and storage of information; and advance directives.</p> <p>The policy ensures that all residents or their family/enduring power of attorney (EPOA) are informed about the management and care to be provided in order that they may arrive at a reasoned and non-pressured decision about any proposed treatment or procedure. It describes what consent involves and how it may be facilitated, obtained, refused and withdrawn.</p> <p>The information pack provided on admission includes information regarding informed consent. The CM or a registered nurse (RN) discuss informed consent with family and the resident during the admission process to ensure understanding. Resident files reviewed demonstrated that informed consent was obtained.</p> <p>Staff receive orientation and training on informed consent and staff interviews confirmed they are aware of the informed consent process.</p> <p>There is an advance directives and an end of life decision policy to ensure that appropriate ethical concepts are upheld in resident treatment and care situations in relation to end of life. The policy defines the procedure for obtaining an advance directive and who may or may not make an advance directive. File reviews demonstrated that advance directives and resuscitation orders were completed in accordance with policy.</p>
<p><b>Standard 1.1.11: Advocacy And Support</b></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.</p> <p>Information regarding the availability of the Nationwide Health and Disability Advocacy Service is included in the information provided to residents and family in admission pack. The advocacy service has visited the facility to discuss their services with residents. Additional advocacy services brochures are also available at the entrance to the facility. The complaints policy also includes making residents aware of their right to advocacy when making a complaint.</p> <p>Interview with the BCM confirmed that advocacy services can be accessed through the Nationwide Advocacy Service and the local Age Concern. These services had been facilitated for residents, when required. Interviews with residents and family confirmed that they are aware of the right to advocacy and that advocacy services are available. The service accessed a palliative outcomes initiative (POI), through the local hospice. A social worker from this initiative visits the facility once a week and is available to speak to residents and their families when required.</p>

<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Observations and resident, family and staff interviews confirmed that residents may have access to visitors of their choice. There are areas where a resident and family can meet in private. Interviews with residents and family and observation, confirmed that families are welcome in the facility and were free to visit at any time.</p> <p>Interview with residents, families and staff confirmed that residents are free to leave the facility and do so to be involved in family events, visit local clubs and go shopping. There are regular trips available to a local mall for those residents who wish to go shopping. The activities programme, and the content of care plans include twice weekly outings in the community to places of interest and these include meeting up with residents of another rest home for picnics.</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 and explained by the BCM or receptionist on the resident's admission. The complaint forms are also available at the entrance to the facility.</p> <p>The BCM is responsible for managing complaints. There had been 11 complaints since the previous audit. An up-to-date complaints register is in place. Evidence relating to each lodged complaint is held in the complaints folder and register and this includes timelines for managing and signing off each complaint. 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>Resident and family interviews confirmed that they are aware of the complaints process. Meeting minutes confirmed that residents are free to raise any concerns and provide feedback on services through resident meetings. Residents and family stated that they could raise any issues directly with the BCM or CM and that they were satisfied with how issues raised had been dealt with.</p> <p>There have been no complaints to external agencies since the previous audit. There was one complaint to the Health and Disability Commissioner (HDC) regarding the standard of care for a resident in care over November and December 2016 that remains open. The HDC has issued a provisional report with proposed recommendations. At the time of the on-site audit Oceania was in the process of implementing those recommendations.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</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 pack includes information on the complaints process. The business and care manager (BCM) or the receptionist explain the Code during the admission</p>

rights.		<p>process to ensure understanding.</p> <p>The Code and associated information are available in brochures which are displayed throughout the facility and available to take away and read in private. Posters with information on the Code in English and te reo Māori are displayed close to the entrance of the facility. This information is also available on the website, various and additional brochures can be obtained in different dialects if required.</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>	FA	<p>The organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code to ensure that a resident's right to privacy and dignity is upheld.</p> <p>Resident, family and staff interviews and observation confirmed that: staff knocked on bedroom and bathroom doors and announce themselves prior to entering; keep files out of sight; ensured that doors were shut when personal cares were being provided; and ensured residents were suitably attired and covered when taken to the bathrooms. Interviews and observation confirmed that conversations of a personal nature were held in private and confidentiality was maintained. All cares including blood tests and dressings are undertaken in the privacy of the resident's bedroom. Residents and family members' interviews confirmed that resident privacy is respected.</p> <p>The organisation has a policy on sexuality and intimacy that acknowledges residents' rights to privacy and intimacy as identified by each resident. It includes identifying resident needs and responding to expressions of sexuality. Resident and family interviews and observation confirmed that residents had access to the hairdressers and could wear clothing and makeup of their choice each day. There is a men's group, facilitated by one of male staff members, that enables male residents to get together and engage in gender orientated activities.</p> <p>Residents' files reviewed, staff, and family interviews and satisfaction surveys confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented and upheld.</p> <p>There is an abuse and neglect policy that sets out the guidelines to prevent, identify, report and correct incidences of abuse and neglect. It includes managing the risk to residents and staff arising from abuse or neglect. Staff receive orientation and mandatory annual training on abuse and neglect. There were no documented incidents of abuse or neglect and this was confirmed in staff and resident and family interviews.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori</p>	FA	<p>The organisation has a Māori health plan/policy that demonstrates Oceania Healthcare Limited's (Oceania) commitment to ensuring residents who identify as Māori have their needs met in a manner that respects and acknowledges their individual and cultural values and beliefs. There is also a culturally competent services policy that describes for staff how culturally competent services should be</p>

<p>have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>delivered.</p> <p>Interview with the BCM confirmed that support for staff to provide culturally appropriate care, and for Māori residents and their families, would be sourced if required through a marae at Waitakere Hospital. Staff receive training in cultural safety and values at orientation and as well as part of the mandatory annual education programme. There were five residents who identified as Māori at the time of audit. Staff and resident interviews confirmed that Māori cultural protocols were respected and upheld.</p> <p>Staff interviews confirmed awareness of the importance of involving whānau in the delivery of care and that the facility enabled tangihanga to be held on site.</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>	<p>FA</p>	<p>Staff and family interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family are involved in assessment and care planning processes.</p> <p>The compendium/information booklet advises residents and family that the facility can provide care to meet cultural, ethnic and spiritual 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 activities that are tailored to meet identified needs and preferences. Staff and resident interviews confirmed that residents' religious and cultural festivals and events were celebrated. This included providing transport for residents to attend external events of a cultural significance.</p> <p>The spirituality and counselling policy ensures access for residents to a chosen spiritual advisor or counsellor where requested. For those residents who chose to attend, the Catholic church provides an interdenominational service and communion once a week. There is a Presbyterian church service once a month. The Salvation Army, located close to the facility, are available to provide spiritual support when required. A staff member, who is a pastor, is available to provide room blessings when requested.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There is policy to ensure that the environment for residents is free from discrimination; coercion; harassment; and financial exploitation. The policy describes for staff how this will be prevented and, where suspected, reported.</p> <p>Job descriptions identify the responsibilities of the position, including ethical issues relevant to each role. Staff interviews confirmed awareness of their obligation to report any evidence of discrimination,</p>

		<p>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>All staff are required to sign and abide by the Oceania code of conduct on employment. Staff mandatory training includes professional boundaries. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Interviews with residents and families 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>Amberwood Rest Home (Amberwood) implements Oceania policies and procedures. These are current and based on good practice and current legislation and guidelines. Policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice.</p> <p>Training programmes are provided to all staff that include the implementation of policy and procedures good practice service delivery.</p> <p>The facility data is entered onto the Oceania electronic database and benchmarking occurs across all Oceania facilities. The regional clinical and quality manager (CQM) reviews all data monthly. The CQM visits the facility monthly and reviews and discussed clinical indicators with the clinical manager (CM). There is also regular contact, when required between the BCM and the regional operations manager and where required performance measures and data are discussed. Staff interviews and monthly meeting minutes identified that the results of benchmarking and clinical indicators are made available to, and discussed with, staff, along with strategies to improve results.</p> <p>Staff, resident and family interviews, residents' progress 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 resident and family interviews demonstrated that family are informed if the resident has an accident/incident; a change in health or a general practitioner (GP) visit. Family contact is recorded on accident/incident forms and in residents' files.</p> <p>Staff, resident and family interviews confirmed that family are included in the resident's care planning and multidisciplinary team (MDT) meetings. Monthly resident meetings inform residents and families of facility activities. A monthly gazette advises residents and families of upcoming events and activities.</p>

		<p>Facility meetings are advertised on the facility notice board, in the facility's gazette and on the monthly activities planner. Minutes of meetings demonstrate good attendance by residents and families. Meetings also provide an opportunity to provide feedback and make suggestions and discuss issues/concerns. Minutes of the resident meetings sighted provided evidence that a wide range of subjects are discussed such as, but not limited to: updates on resident and staff movements; an activities update; the resident safe handling programme; infection control and the Code. Copies of the meeting minutes are available to residents in hardcopy. Copies of the current activities plan, and four weekly menus are also available to residents and families.</p> <p>Resident and family interviews confirmed that the BCM and staff were approachable and available to discuss queries and issues. Interviews identified that concerns and queries were addressed promptly and proactively.</p> <p>There is a 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 with the BCM confirmed that interpreter services can be sourced externally, although these have not been required. Staff represent a number of ethnicities such as Fijian Indian, Indian and Māori, and can communicate with residents in their native tongue if the resident wishes. Other options to facilitate interpretation included a computerised electronic language converter and a board with a list of translations for key phrases. At the time of the audit there were five residents for whom English was not their first language.</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 Group with the executive management team providing support to the facility. Communication between the facility and Oceania executive management occurs monthly with the CQM providing support during the audit. An Oceania relief BCM (national role), was also on site during the audit undertaking a review of clinical systems. The monthly management report provides the executive management with progress against identified indicators.</p> <p>Oceania has a documented mission statement, vision and values. These are displayed at the entrance to the facility.</p> <p>There is an overarching Oceania business plan. In addition, there is a 2019–2020 operational and business brief specific to Amberwood that includes a competitor analysis and sets out the market expectations of the facility.</p> <p>The facility is managed by a BCM who has been in this role for two years. The BCM is a RN and has 26 years' experience in aged related residential care (ARRC), including 10 years as manager. The BCM has a diploma in business and has completed Oceania leadership training.</p>

		<p>The clinical care at the facility is overseen by the CM who has been in the role for two years and has recently returned after a seven month period of leave. The CM has 10 years' experience as RN at Amberwood and another Oceania facility, and has completed leadership training.</p> <p>The facility is certified to provide rest home and hospital care for up to 70 residents in 69 dual purpose beds and 1 rest home level bed. Of the total number of beds, 68 were available for use at the time of audit as one double room was being used for other purposes. There were 57 beds occupied at the time of the audit, this included: 35 residents who had been assessed as requiring hospital level care and 22 residents assessed as requiring rest home level care.</p> <p>The facility has contracts with the district health board (DHB) for the provision of rest home, hospital level care, and chronic health conditions. The ARRC contract includes respite care and palliative care in ARRC. Included in the total occupancy numbers were three residents who were receiving care under the chronic health conditions (CHC) contract assessed at hospital level care, two of whom were under the age of sixty-five years. Also included in the total occupancy numbers were two residents receiving respite care assessed as requiring 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 an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a short-term temporary absence of the BCM, the CM, with support from the regional operations manager, would be responsible for the day to day operation of the service. In the advent of a longer BCM absence an Oceania relief BCM would fulfil the role. During the absence of the CM, the BCM who is a RN, would provide clinical cover with the support of the regional CQM and RNs.</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>	FA	<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 sighted were current and align with the Health and Disability Services 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 meetings and made available in the staff room. Staff are also made aware of any policy and procedural changes through the electronic log in system. A review of staff meeting minutes and interviews confirmed that staff are made aware 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 several clinical</p>

		<p>indicators such as: health and safety; incidents and events; near misses; infections; falls; skin tears; and medication errors.</p> <p>There was evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data sighted provided evidenced that data is being collected and collated with the identification of trends and analysis of data. Corrective action plans are developed, implemented, evaluated and signed off where required. There is communication with staff of any subsequent changes to procedures and practice through monthly meetings.</p> <p>The staff, quality, infection control and the health and safety 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. Staff sign to acknowledge that they have read the meeting minutes.</p> <p>Residents and families are notified of relevant updates through the facility's resident meetings. Satisfaction surveys for residents and family are completed as part of the internal audit programme. Corrective actions are developed and implemented for issues identified from surveys. The 2019 surveys reviewed evidenced satisfaction with services provided and this was confirmed by family interviews.</p> <p>The organisation has a risk management programme in place that records the management of risks in clinical, environment, human resource and other areas specific to the facility. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and their responsibility to report hazards, accidents and incidents promptly. Health and safety events such as: a review of hazard reports; maintenance; new equipment; and new staff induction are discussed at health and safety meetings.</p> <p>There are six nominated and elected health and safety representatives from key areas. The BCM is the health and safety coordinator.</p> <p>Hazard reporting forms and staff interviews confirmed that hazard reporting is actively encouraged. There was evidence that identified hazards are addressed promptly and risks minimised. A current hazard register is available, and this is reviewed annually, with a section reviewed at each monthly health and safety meeting. Hazards, such as a new deck construction, are sign posted with associated hazards identified.</p>
Standard 1.2.4: Adverse Event	FA	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

<p>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>notify statutory authorities. Interviews confirmed that these would be reported to the appropriate authority by the Oceania support office. There have been no events since the last audit requiring essential notification.</p> <p>Interviews with staff and review of adverse event forms confirmed that all staff recognise and report adverse events. Staff interviews confirmed an understanding of the adverse event reporting process and their obligation to document all untoward events. A review of staff records demonstrated that staff receive education at orientation on the accident/incident reporting process.</p> <p>There is an implemented accident/incident reporting process and accident/incident reporting forms are available on the notice board in the staff room. Interviews with staff and review of documentation evidenced that staff document adverse, unplanned or untoward events on an accident/incident form which are signed off. Accident/incident reports selected for review evidenced that an assessment had been conducted and observations completed. There is evidence of a corresponding note in the resident's progress notes and notification of the resident's nominated next of kin where appropriate.</p> <p>Corrective actions arising from resident and staff accidents/incidents were implemented. Information gathered is shared at monthly meetings with accidents/incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Results and corrective actions from accidents/incidents are regularly shared at meetings.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; a signed employment agreement; position specific job description; and police vetting.</p> <p>The facility maintains records of, and tracks: staff training; competencies and performance appraisals. There are systems to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that require them including: RNs; GPs; physiotherapist; podiatrist; pharmacists; and dietitian. An appraisal schedule is in place and all files reviewed, for staff who had been employed for greater than one year, evidenced a current performance appraisal.</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 by experienced staff over their orientation into their new roles. Competencies are reassessed annually. Annual competencies are completed by care staff include, for example: hoist uses; showering and dental care; infection control; restraint comprehension; and medication management. Seven of ten RNs have completed interRAI</p>

		<p>assessments training and competencies.</p> <p>The organisation has implemented the Oceania documented role specific mandatory annual education and training modules. Staff have access to external training such as the two day palliative care fundamentals. Education session attendance records evidenced that ongoing education is provided. Training records and interviews confirmed that staff have undertaken a minimum of eight hours of relevant training.</p> <p>A review of the management system confirmed that processes are in place to ensure that all staff complete their required training and competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery.</p> <p>Rosters are confirmed and made available to staff one month in advance. Staffing levels are reviewed to accommodate anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes residents' needs and numbers. There are sufficient RNs and health care assistants (HCAs) available, including provision for an extra shift, to safely maintain the rosters for the provision of care to accommodate increases in workloads and acuity of residents.</p> <p>The facility is made up of two wings, one side predominantly for residents with lower acuity such as, rest home residents and another for higher acuity residents and predominantly those assessed as hospital level. There is a centrally located nurses' station.</p> <p>In addition to the BCM and the CM, who are on duty on the morning shifts from Monday to Friday, there is an RN on duty in each wing on the morning and afternoon shifts and one on for the entire facility on night shift.</p> <p>In the wing with predominantly higher acuity residents, there are six HCAs on each morning, five in the afternoon and two on each night shift, seven days per week. In the wing with residents with a lower acuity there were: four HCAs on each morning and three on each afternoon shift. On night shift there were either two HCAs or an HCA and an enrolled nurse on each night shift, seven days per week.</p> <p>Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract. In each wing there is at least one staff member who has current medication competencies and a current first aid certificate on each shift.</p> <p>There are 74 staff, including: the management team; administration; clinical staff; activities assistants; and household staff. Household staff include cleaners, laundry assistants and kitchen staff who provide services seven day a week. The BCM or the CM are rostered on call after hours to the rest home and</p>

		<p>hospital.</p> <p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed that they are at times busy when there are more complex or higher numbers of residents but can complete their scheduled tasks and resident cares over their shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Residents' records are maintained in hardcopy with electronic medication charts in use. Residents' information, including progress notes, are legible and entered into the resident's record in an accurate and timely manner, identifying the name and designation of the person making the entry. Residents' progress notes are completed every shift, detailing the resident's response to service provision.</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of their obligations to maintain the confidentiality of resident information. Resident care and support information can be accessed in a timely manner and is protected from unauthorised access by being locked away when not in use. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the resident's family and resident where applicable.</p> <p>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel only.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Prior to residents entering to the facility, Needs Assessment Service Coordination (NASC) assesses potential residents as requiring rest home or hospital level care utilising the interRAI assessment tool as evidenced by data provided. The facility communicates with the NASC and other applicable agencies to ensure efficient and timely admission. The NASC service and/or the GP provides information prior to a resident accessing respite care.</p> <p>The facility provides residents and families with an information pack containing all relevant information. Resident's admission agreements evidenced resident and/or family and facility representative sign off.</p> <p>In interviews, residents and family confirmed the admission process was completed by staff in a timely manner, relevant admission information was provided and a discussion held with staff in respect of resident care conducted.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The resident's exit, discharge or transfer is managed in a planned and coordinated manner. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident, this was witnessed on site in handover and in review of resident's files. Families interviewed reported timely communication 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 is an electronic medication system in place with appropriate processes that comply with current legislation requirements and safe practice guidelines. The medication areas evidence an appropriate and secure medicine dispensing system. Medications are stored free from heat, moisture and light, in original dispensed packs and in secure trolleys. The drug register is maintained and evidenced weekly checks and six-monthly physical and pharmacy stock takes. Records of temperature checks for the medicine fridge are maintained and evidenced temperatures within the recommended range.</p> <p>Staff authorised to administer medicines have current competencies. A medication round was observed and evidenced the staff member was familiar about the medicine administered. Medications were signed off after the dose was administered and protocols and procedures were followed. Administration records and specimen signatures are maintained.</p> <p>There is a policy for residents who self-administer medications. There were no residents self-administering medicines at the facility at the time of the on-site audit.</p> <p>Patients who are in the facility for respite care have an individual folder and a paper chart. The medications are recorded and signed for by the individual resident's GP. The regular and as required medications are signed as administered on a signing sheet by an authorised staff member.</p> <p>Electronic medication charts evidence current resident photograph identification, and allergies and sensitivities are recorded. Mandatory three-monthly reviews were conducted by the GP and evidenced on the charts.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a</p>	<p>FA</p>	<p>The menu reviewed is in line with recognised nutritional guidelines for older people, as verified by a dietitian's assessment and six-monthly review.</p> <p>In the past year there has been an upgrade of the food service, refurbishment of the dining rooms and staff training as a result of resident meetings and surveys. There was documented evidence of residents and families being satisfied with the changes, and this was confirmed on interview with residents and families. Residents are able to provide ongoing feedback on the food service at the</p>

<p>component of service delivery.</p>		<p>resident's meeting and through resident surveys.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weight. Special equipment and adequate crockery, to meet residents' nutritional needs, was sighted.</p> <p>A dietary assessment is completed for each resident on admission and a dietary profile developed. The dietary assessments, including allergies, likes and dislikes, are documented in the residents' files and in the kitchen. The individual resident food plan is reviewed by the cook to reflect and confirm the residents' dietary requirements. Interview with the cook identified residents' dietary needs were reviewed as required and/or if there was a change in a resident's need or health status.</p> <p>The kitchen was observed to be clean and there was maintained kitchen cleaning roster for all equipment. The service operates an approved food control plan applicable to all Oceania facilities. The food control plan was current. Food temperatures are monitored and recorded as part of the food control plan. All food service staff have undertaken annual safe food handling qualification and completed relevant food handling training.</p> <p>The fridges, chillers and freezer are recorded and documented; this includes fridges in resident's rooms and lounges. Decanted food was dated and expiry dates recorded. Food in the fridges was dated and covered. There was no food stored on the floor. Nutritional supplements made up in the kitchen were dated and expiry dates were evidenced.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</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>If admission to a service is declined residents and their families are informed in an appropriate manner of the reasons why the service had been declined in line with the service's policy. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.</p> <p>As confirmed at management interviews, entry to the service would be declined if the care level is not within the scope of the service or if a bed was not available.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a</p>	<p>FA</p>	<p>The NASC InterRAI assessment data and other assessments completed by RNs on admission are utilised to inform the initial care plan. Resident needs are identified through a variety of information sources including GPs, specialists, other service providers, the resident and family. The facility utilises the Oceania assessment tools in addition to interRAI. The residents' files also evidenced any completed discharge/transfer information from the DHB where relevant.</p>

<p>timely manner.</p>		<p>The clinical files reviewed evidenced all residents had interRAI assessments and PCCPs completed within 21 days of their admission. The files reviewed showed the residents had current interRAI assessments completed by trained RN interRAI assessors in the facility. There was evidence the results of the interRAI assessments were discussed with the residents and where appropriate the family.</p> <p>Interviews with residents and families confirmed they were involved in assessments and that assessments are held in a safe and appropriate setting, including visits from the GP and specialists.</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>InterRAI assessment informs the PCCP and resident/family input is sought. Care plans reviewed were individualised and defined the required support and interventions for each resident.</p> <p>Care plans reviewed for residents, including residents under the chronic health conditions contract; were integrated and current. The care plan interventions reflect the risk assessments and the level of care required. Short-term care plans are developed when required and signed off by the RN when short term problems are resolved.</p> <p>In interviews, staff reported they receive timely and appropriate information for continuity of residents' care. The residents and/or families have input into their care planning and evaluation. Consistent GP care was evidenced in GP progress reports and confirmed at GP interview.</p> <p>Reviewed care plans demonstrated service integration with progress notes. Resident activities records, and medical and allied health professionals' notations were clearly written in the resident files.</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>The residents' care plans reviewed evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents.</p> <p>Interviews with residents and families confirmed the care and treatment delivered met their needs and desired outcomes. Reviewed documents showed evidence of resident contact and links to community services as required. Staff interviewed confirmed an established understanding of the resident's needs and interventions. Family communication is recorded in the resident's file and family interviews confirming communication occurs. Progress notes, GP records and observation charts reviewed were current.</p> <p>The facility has appropriate resources and equipment, as confirmed at staff interviews and through observation of the facility. The equipment available complied with best practice guidelines and met the residents' needs.</p>

<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one activities programme which includes rest home and hospital residents. Activities are planned by an activities coordinator and delivered Monday to Friday from 8.30 am until 7.30 pm by activity assistants. Family/whānau and friends are welcome to attend all activities. The monthly activities programme is reviewed and updated monthly. There is an activity meeting quarterly and includes input from clinical staff, management and the cook.</p> <p>The activities programme reviewed included cognitive, social groups and one-on-one activities including voluntary religious events appropriate to the variety of resident cultures. Social outings are provided for those residents able to partake. The activities programmes include input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. The activities coordinator confirmed the facility provides appropriate equipment for implementing the activities programme.</p> <p>Daily exercises for all residents who wish to partake are overseen by a physiotherapist assistant and the activities coordinator. The facility physiotherapist oversees the strength and balance programme based on the 'Live Stronger for Longer' programme endorsed by Accident Compensation Corporation (ACC), the Ministry of Health and the Health Quality &amp; Safety Commission.</p> <p>The residents are assessed to establish their individual interests, suitable activity and social requirements. There were current, individualised activities care plans in residents' files sighted. The planned monthly activities programme reviewed corresponded with the skills and interests shown in the residents' files, including younger residents with long-term chronic health conditions.</p> <p>In interview, the activities coordinator confirmed activities are voluntary for residents, but they are encouraged to attend. Resident attendance was documented, and activities progress notes are recorded monthly by the activity coordinator.</p> <p>Activity requirements are evaluated as part of the formal six-monthly care plan review. The residents' meeting minutes evidence discussion and residents' involvement in planning the activities programme. Residents interviewed confirmed satisfaction with the activities programme.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Formal care plan evaluations are carried out by the RNs and documented on the PCCP following reassessments to measure to ascertain the degree of a resident's response in relation to desired outcomes and goals. Reassessments are completed every six months, or when changes in resident's health status occurs, using the InterRAI tool. Reassessments completed within the required timeframes were evident in resident files reviewed, including when a resident had a change in health status.</p> <p>There was evidence of resident, family, RNs, HCAs, activity coordinator and GP input into care plan</p>

		<p>evaluations. There was evidence of additional input from other health professionals and specialists if required. In interviews, residents and family confirmed their participation in care plan evaluations and MDT reviews. The residents' care plans were up to date and reviewed at mandatory six-monthly intervals.</p> <p>The residents' progress notes are completed on each shift and there is evidence in reviewed files that residents' care is evaluated and reported on, if any change is noted it is reported to the RN. This was demonstrated in the handover observed during the on-site audit. When resident's progress is different than expected, the RN contacts the GP if required, as confirmed at GP interview.</p> <p>A short-term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's overall health or cognitive condition. Short-term care plans are reviewed by the RN daily, weekly or fortnightly as seen in the clinical files. The family are notified of any changes in resident's condition, three-monthly GP reviews, and care plan evaluations, as confirmed at family interviews.</p> <p>Wound care plans evidenced appropriate and current evaluations.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Files reviewed validated processes are in place to support resident's accessing or being referred to other health or disability services. Interviews with families confirmed family involvement and information sharing. There is evidence of an effective MDT approach to consultation and this was seen in the clinical files reviewed.</p> <p>There was evidence of non-urgent and routine referrals in the resident files. Copies of referrals and consultations were sighted in resident's files including surgeons, radiology, psychogeriatric services, wound care specialists and other health professionals. Referrals are followed up by RNs and the GP. Prescribed medications and other directions from external health providers were evidenced in the files.</p> <p>Acute or urgent referrals were evidenced as being responded to immediately such as sending a resident to accident and emergency via ambulance if required.</p> <p>In interview the GP confirmed sudden or acute changes in a resident's health status is communicated with them and involved in acute referrals to the DHB.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service</p>	<p>PA Low</p>	<p>Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling and disposal of and collecting waste. However, the management of refuse and basement storage required attention. A current hazard register is available and current.</p>

<p>providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>Current material safety data posters are available and accessible to staff in relevant places in the facility, for example, in the sluice room. Staff complete a chemical safety training module on orientation and the product supplier provides ongoing training in the safe use of chemicals.</p> <p>Staff receive training and education in waste management and infection control as a component of the mandatory training.</p> <p>Interviews and observations confirmed that there is sufficient personal protective clothing and equipment provided, such as aprons, gloves and masks. Interviews confirmed that the use of personal protective clothing and equipment is appropriate to the recognised risks. Observation confirmed that personal protective clothing and equipment was used in high-risk areas.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plants, and equipment comply with relevant legislation.</p> <p>A preventative and reactive maintenance schedule is implemented. This includes monthly maintenance checks of all areas and specified equipment such as hoists. Staff identify maintenance issues in a maintenance log book. These are reviewed daily by the maintenance person and attended 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>Interviews with staff and visual inspection confirmed there is adequate equipment available to support care. The facility has an annual test and tag programme, undertaken by the maintenance person, that is up to date. Evidence of checking and calibration of biomedical equipment, such as blood glucose monitoring machines, oxygen concentrators, hoists and air mattress pumps, was sighted. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained. Inspection confirmed that the van has a current registration, warrant of fitness, first aid kit, fire extinguisher and functioning hoist. Interviews with staff interviews and documentation evidenced that those staff who drive the van have a driver's licence and complete annual van driving and competency assessments.</p> <p>Hot water temperatures are assayed monthly and these were completed on the day of the audit. A review of temperature assays and interview with the maintenance person confirmed that where hot water temperatures have been above the recommended safe temperature, action is taken by a plumber, and confirmed to ensure that they are within recommended temperature range.</p> <p>All resident areas can be accessed with mobility aides. There are internal and external courtyards and decks accessible from both wings. The external decked areas have outdoor seating and shade and can be accessed freely by residents and their visitors.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is a mixture of rooms with their own ensuite toilets; shared toilet ensuites; or shared full ensuites. All other rooms have access to communal toilet and bathroom facilities. There are sufficient accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility.</p> <p>Communal toilets have a system to indicate vacancy and have disability access. There are two visitor toilets. All shower and toilet facilities have call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and to promote independence.</p> <p>Residents were observed being supported to access communal showers in a manner that was respectful and maintained the resident's dignity.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Residents have their own room, and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. The designated dual-purpose rooms have sufficient space to facilitate the use of a hoist. Observation and interviews with residents confirmed that there was enough 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 within the facility to store equipment such as wheel chairs, walking frames, commodes and hoists, tidily (refer to 1.4.1.1).</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is a lounge/dining room in each wing. All internal communal areas have seating and external views. Areas can be easily accessed by residents, family and staff. There are areas that are available for residents to access with their visitors for privacy if they wish. 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 are areas for storing activities equipment and resources (refer to 1.4.1.1). There are areas in each wing, including lounge areas and external decks, that are used for activities.</p> <p>Most residents were observed to have their meals with other residents in the communal dining rooms but they can have their meal in their own room if they prefer.</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' personal clothing, is completed on site by an Oceania business unit managed separately to the facility. Colour coded, covered laundry trolleys and bags were observed to be used for transport. There is one laundry assistant on each duty in the facility, responsible for unpacking, sorting and delivering laundry to residents, for four hours, seven days a week. Interview with the laundry assistant, who also worked shifts in the kitchen, confirmed on the days rostered onto the laundry, that duties were confined to laundry functions only. Household staff interviewed confirmed knowledge of their role including management of any infectious linen.</p> <p>A cleaner is on duty seven days a week and cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemicals on a trolley when cleaning and interview and observation confirmed awareness of the need to keep the trolley with them at all times. Staff receive training in correct use of cleaning products.</p> <p>There are sluice rooms available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility with alcohol gels in various locations.</p> <p>The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Resident and family interviews, 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. Staff interviews and training records confirm that fire wardens received warden training and staff have undertaken fire training. There is a nominated fire warden on each shift for each area.</p> <p>The staff competency register evidenced that 24 staff have current first aid certificates. There are at least two staff members on each shift with a current first aid certificate.</p> <p>The facility has sufficient supplies to sustain staff and residents in an emergency situation (refer to 1.4.1.1). Alternative energy and utility sources are available in the event of the main supplies failing. These include: gas for cooking; emergency lighting; and enough food, water, water purification tablets, dressings and continence supplies (refer to 1.4.1.1). The service's emergency plan includes considerations of all levels of resident need.</p>

		<p>Call bells are available to summon assistance in all resident rooms and bathrooms. Call bells are checked monthly by the maintenance person. Observation and family interviews confirmed that call bells are answered promptly.</p> <p>Security systems are in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building and the facility being locked in the evenings with restricted entry by call bells, afterhours, external security cameras and staff conducting scheduled security check of external doors.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas accessed by residents have safe ventilation and at least one external window providing natural light. Resident areas in the facility are heated by a combination of ceiling and wall panel heaters in the winter. On the day of the audit the external temperatures were noted to be high. Fans were observed to be utilised for cooling and the environment in resident areas was noted to be maintained at a satisfactory temperature. Interviews with staff, residents and families confirmed that during hot weather residents were provided with extra fluids, ice blocks, and cold flannels to manage the heat. Systems are in place to obtain feedback on the comfort and temperature of the environment.</p> <p>The facility has a one designated external smoking area. At the time of the audit there were three residents who smoked.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The CM is the designated infection control nurse (ICN). The ICN is responsible for implementing the infection control programme at Amberwood. There is an infection control committee with representatives in each area of the service management team. This group meets monthly and infection control matters are discussed at the facility monthly quality meetings. Minutes were sighted and are available for staff.</p> <p>The Oceania group infection control programme is utilised at Amberwood. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The infection control programme is reviewed annually at organisational level.</p> <p>Staff were observed performing hand hygiene and using required products for infection control. There are processes in place to isolate infectious residents when this is required.</p>
<p>Standard 3.2: Implementing the</p>	FA	<p>The ICN has access to relevant and current information to implement the infection control programme. The ICN confirmed in interviews there are adequate resources to implement the programme.</p>

<p>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>Interviewed staff reported that there are sufficient infection control resources and equipment for use.</p> <p>Infection control is an agenda item at the facility's staff and quality meetings, as evidenced during review of meeting minutes and interviews with staff. The internal audit programme includes infection control audits to monitor the implementation of the infection control programme.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control policies and procedures manual provide information and resources to inform staff on infection prevention and control. The policies and procedures conform with relevant legislation and current known good practice and are reviewed regularly.</p> <p>Staff interviews confirmed they were aware of infection control procedures and could identify where policy and procedure manuals were kept.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control and infection prevention are part of orientation and annual mandatory training. The ICN has current training in infection control. The ICN and the relief BCM are responsible for staff education on infection prevention and control, as evidenced in review of staff files. The education provided is current and relevant to the size and purpose of the service. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p> <p>There is evidence of appropriate resident and family education in the monthly gazette and notices around the facility.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods</p>	FA	<p>The ICN maintains infection logs for residents' infection events. Residents' files evidenced any residents' who were diagnosed with an infection had short-term care plans in place. The GP reported being informed in a timely manner when a resident has an infection and appropriate measures are taken to manage the infection.</p>

<p>that have been specified in the infection control programme.</p>		<p>There was evidence of monthly surveillance analysis being completed and reported at staff meetings. Infection control data is entered in the clinical indicators on the Oceania intranet. All infection control information is reviewed by the Oceania national clinical quality team and reported to the Oceania board.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs and ICN by verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>There has been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There were no restraints or enablers at the time of audit.</p> <p>The Oceania restraint minimisation and safe practice handbook and policies comply with this standard and relevant legislation. Clinical staff interviews confirmed enablers are used voluntarily at a resident's request.</p> <p>The CM is the restraint coordinator and a job description was evidenced. The restraint meetings are held three-monthly with the CQM, RNs and physiotherapist. Restraint minimisation is in the orientation package and mandatory annual staff education, validated by meeting minutes and education records.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	PA Low	<p>There are cleaning staff on duty each day and rubbish bins within the facility were observed to be cleared before they became full. Rubbish was stored for collection by an external contractor in large bins in an allocated bay outside the facility. There were allocated places for storing equipment/supplies within the facility and equipment/supplies in these areas were observed to be stored in an organised manner. However, external storage management of refuse and basement storage of equipment/supplies requires attention.</p>	<p>i) Two refuse bins were observed to be over flowing and one was not covered.</p> <p>ii) The underfloor storage of equipment maintenance supplies, including the emergency water supply, was cluttered and did not provided a clear unobstructed path to retrieve items.</p>	<p>i) Ensure all refuse is covered and contained securely.</p> <p>ii) Ensure underfloor storage of equipment/supplies is safe and easily accessible.</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.