

Oceania Care Company Limited - Ohinemuri Rest Home and Village

Introduction

This report records the results of a Surveillance 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:	Ohinemuri Rest Home and Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 12 March 2020 End date: 13 March 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	65

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

Ohinemuri Rest Home and Village is a facility within Oceania Healthcare Limited that can provide care for up to 68 residents requiring rest home, hospital or dementia level of care. Occupancy on the first day of the audit was 65.

This surveillance audit was conducted against the relevant Health and Disability Service Standards and the service contract with the district health board.

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

The previous requirement for improvement at the certification audit relating to meeting timeframes for service delivery, has been closed.

There was one area identified as requiring improvement at this audit relating to service delivery interventions.

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 Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is provided to residents on admission and available within the facility.

Staff communicate with residents and family members following any accident/incident and this is recorded in the residents' files.

Residents, family and the general practitioner interviews confirmed that the environment is conducive to communication, including identification of any issues, and that staff treat residents respectfully.

There is a documented complaints management system and a complaints register is maintained. The business and care manager is responsible for managing complaints. Complaints are investigated and documented, with corrective actions implemented where required.

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 has a strategic plan, mission, vision and values. Ohinemuri Rest Home and Village submits reports to the Oceania Healthcare Limited national support office allowing for ongoing monitoring of service delivery.

The facility is managed by an appropriately qualified and experienced business and care manager, supported by a clinical manager responsible for the oversight of clinical service provision. The business and care manager and clinical manager are registered nurses and hold current practising certificates. The facility management team is supported by the regional clinical quality manager and the regional operations manager.

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement.

Quality and risk performance is monitored through the organisation's reporting systems. An internal audit programme is implemented. Corrective action plans are documented from quality activity results, with evidence of the resolution of issues when these are identified. There is an electronic database to record risk in which risks and controls are clearly documented.

A system is in place to report, analyse, and respond to adverse, unplanned, or untoward events. Adverse event information is openly shared with affected residents and their family members of choice where appropriate.

Oceania Healthcare Limited human resource policies and procedures are implemented. Practising certificates for staff and contractors who require them are current and validated annually. Newly recruited staff undertake orientation appropriate to their role. An annual training plan is implemented to ensure ongoing training and education for all staff members.

Registered nurses are on duty 24 hours a day, 7 days a week and are supported by care and allied health staff. A review of rosters and service delivery staffing, as well as resident/family interviews, confirmed that staff number and skill mix available are sufficient to provide safe service delivery.

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.		Some standards applicable to this service partially attained and of low risk.
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Resident records sampled provided evidence that registered nurses complete resident initial assessments to inform the initial care plan prior to the development of the long-term person centred care plan. General practitioner medical assessments are completed within 48 hours of admission. Medical reviews are completed regularly thereafter or sooner if required.

The interRAI assessments are completed within the required timeframes and inform each resident's electronic long-term care plan. Care plans are individualised and include family input where applicable. Short-term care plans are in place for short-term issues such as wounds or following a resident fall. Interviews confirmed residents and their families are informed and involved in the care planning and evaluation of care. Handovers between shifts guide continuity of care. A multidisciplinary approach was evident in resident records reviewed.

The activity programme is managed by an activities coordinator undertaking diversional therapist training and is supported by two activities coordinators. The programme provides residents with individual and group activities. Residents identified with cognitive change are supported daily with suitable activities and have access to specific diversional aids appropriate to their needs. Regular community outings are provided. Family and friends visiting are included in activities where desired.

Medicine management occurs according to policies and procedures and in alignment with legislative requirements. Medications are administered by registered nurses and senior health care assistants. Medicine management competencies reviewed for staff who administer medicines were current.

The food service meets the current requirements and has an up to date food control plan. A system is in place to manage new resident's food requirements and any dietary requirements. Residents and family confirmed they were satisfied with food provided. Additional snacks are available to people with cognitive change and those with special requirements.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is displayed in the facility. There had been no alterations to the building since the last audit or the last fire drill.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation implements policies and procedures that support the minimisation of restraint. There were no enablers or restraint in use at the time of audit. Staff interviews confirmed understanding of the restraint and enabler processes. Staff providing care in the dementia unit are cognisant of restraint parameters, triggers and the de-escalation process. When enablers are used, enabler use is voluntary and recorded. A restraint register is maintained.

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 surveillance programme is developed, embedded in practice and reviewed annually. Infection prevention and control surveillance is undertaken and analysed. Trends are identified and reviewed by staff at regular meetings. Surveillance records confirm infections are followed up as required. Staff interviewed demonstrated current knowledge and practice of infection control principles.

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	15	0	1	0	0	0
Criteria	0	38	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)
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 1.1.13: 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 is in line with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and includes the timeframes for responding to a complaint. Complaints forms, and a post box to submit the complaint, are available near the entrance to the facility.</p> <p>Residents and their family members are provided information on the complaints process as part of the admission process. Written information on the complaints process is provided in the admission pack on admission to the facility. The BCM discusses the complaints process with the resident and family to ensure understanding.</p> <p>Staff and resident interviews confirmed residents' awareness of opportunities and processes to raise any concerns and to provide feedback on services. Resident meeting minutes showed documentation that concerns are raised, discussed, and feedback provided on services during residents' meetings. Residents and family interviews confirmed that they are aware they can make a complaint and stated that they were satisfied with how any issues raised had been dealt with and that they had not needed to make a complaint.</p> <p>The BCM is responsible for managing complaints. An up-to-date complaints register is in place and includes: the date the complaint is received; the category of complaint and a summary of the complaint; the date of meetings/discussions with the parties involved; and the date the complaint is closed/resolved. Evidence relating to each lodged complaint is held in the complaints folder with the register. There have been two complaints since the previous audit. A review of documentation during the on-site audit identified that complaints were investigated promptly, and issues resolved in a timely manner.</p>

		<p>The complaints process had been audited as part of the facility's internal audit programme and this also confirmed implementation of the complaints process.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner (HDC) or other external authorities since the previous audit</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>An open disclosure policy sets out the process to guide staff and ensure that there is open disclosure of any adverse event where a resident has suffered unintended harm while receiving care. Completed accident/incident records and residents' records reviewed demonstrated that family are informed if the resident has an accident/incident; or a change in health. Family and resident interviews confirmed that family are informed of any changes in resident status and that they are included in the individual care planning meetings for the resident.</p> <p>Two-monthly resident meetings inform residents of facility events and activities and provide attendees with an opportunity to: give feedback; raise and discuss issues or concerns. Upcoming residents' meetings are included in the activity's planner and facility newsletter. Staff interviews confirmed family are welcome to attend residents' meetings and are invited via an email close to the meeting date. Meeting attendance lists and family interviews confirmed families attend resident meetings if they wish. Minutes from the residents' meetings showed evidence that regular topics and concerns are discussed, including: staff updates; activities programme; household services; infection control; health and safety and general items such as, new equipment/fixtures and fittings; and food services. Minutes also included feedback on services. Copies of meeting minutes are made available to residents and families upon request, otherwise the minutes of previous meetings are reiterated at the subsequent meeting.</p> <p>Residents and family stated that they could raise and discuss any issues or concerns at resident meetings as well as directly with staff. They also stated that the business and care manager (BCM) was approachable to discuss matters and that they were satisfied with the verbal responses received from the BCM. Interview with the BCM advised that residents are visited individually daily to provide an opportunity to discuss any issues or concerns.</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. Staff interviews confirmed that interpreter services would be accessed if required by a resident. At the time of audit there was one resident for whom English was not their first language. Staff interviews confirmed, at the resident's request, family members or a friend had provided translation services when required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation</p>	FA	<p>Ohinemuri Rest Home and Village (Ohinemuri) is part of Oceania Healthcare Limited (Oceania).</p> <p>Oceania has a documented strategic plan, mission, vision and values statement, which reflect a person/family-centred approach to all residents across its facilities. The mission, vision and values are: displayed at the front entrance of the Ohinemuri facility; outlined in the information pack provided to residents and family on admission;</p>

<p>ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>and communicated to staff during their orientation and annual training. Oceania's overarching business plan applies to Ohinemuri facility. Ohinemuri has a facility specific budget with expectations that reflect the facility's future intent for refurbishment and developments.</p> <p>The Oceania executive management team provides support to the facility. Communication between Ohinemuri and Oceania executive management team occurs at least monthly. The facility provides the executive management team with ongoing electronic reporting of events and occupancy, and monthly progress against identified indicators as sighted during the on-site audit.</p> <p>The BCM is responsible for the overall management of the facility and has been in this role for two and a half years, having previously worked as a registered nurse (RN) in aged related residential care (ARRC) for eight years and as a community support worker. The BCM holds a current RN practising certificate and a diploma in health psychology. The clinical manager (CM) supports the BCM and has been in their current role for over three years. They had previously practised as an RN in the facility for 17 years. The CM holds a current RN practising certificate and is supported by the Oceania clinical quality manager (CQM). Both the BCM and CM have completed Oceania management training.</p> <p>Ohinemuri is certified to provide ARRC, rest home, hospital and dementia level care. There were 65 beds occupied at the time of audit. Occupancy included: 32 residents requiring rest home level care; 21 requiring hospital level care; and 12 requiring dementia level care.</p> <p>The facility holds contracts with the district health board (DHB) for ARRC, day care, respite care, long-term support for chronic health conditions (LTS-CHC) and residential non-aged care (YPD).</p> <p>Of the 65 residents, there were 2 assessed at rest home level care who were under 65 years of age. One was under the YPD contract and one under the LTS-CHC contract.</p> <p>The facility has no residents who hold an occupational right agreement.</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</p>	<p>FA</p>	<p>The Oceania documented quality and risk management framework is accessed by staff to guide service delivery.</p> <p>Policies are current, align with the Health and Disability Services Standards, and include references to good practice guidelines. Staff are made aware of policies at orientation as evidenced in staff interviews and orientation records. Oceania has a document control system to manage its policies and procedures. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies are introduced to staff at staff meetings and policy updates are included in relevant in-service education. Staff interviews confirmed that they are made aware of new and updated policies at meetings and education sessions. New and revised policies are available to staff in a folder at the nursing station. There was evidence that staff sign to confirm they have read and understood each new policy and/or update.</p> <p>Service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators</p>

improvement principles.		<p>such as: residents' falls; infections; weight loss; wounds; and medication errors by staff. Clinical indicators are collated monthly. All aspects of quality improvement, risk management and clinical indicators are discussed at monthly staff meetings. Copies of meeting minutes are made available to staff and staff sign to confirm they read these.</p> <p>There is documented evidence that the annual internal audit programme is implemented as scheduled. Reports reviewed show evidence that quality improvement data is being collected and collated with the identification of trends and analysis. Where required, corrective action plans from quality activities are developed, implemented, evaluated and closed out as evidenced in documentation reviewed. Staff interviewed confirmed that they are advised of any subsequent changes to procedures and practice through staff meetings and meeting minutes. Staff interviewed confirmed that they are kept informed of quality improvement activities.</p> <p>Residents and family stated they are notified of quality activities such as the satisfaction survey and infection control practices through the facility's residents' meetings. Interviews with residents and family confirmed they have the opportunity to have input into quality improvement activities. Resident and BCM interviews confirmed that residents and family have input into new equipment for the resident's specific use, such as motorised wheelchairs.</p> <p>Satisfaction surveys for residents and family are completed twice yearly as part of the internal audit programme. Surveys reviewed evidenced overall satisfaction with services provided. Interview with the BCM and a review of survey results evidenced that areas for improvement are identified and actions implemented. Comparison of the previous two surveys during the on-site audit identified there was an improved level of satisfaction documented in the most recent survey results.</p> <p>The organisation has a risk management programme in place. 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 responsibilities to report hazards, accidents and incidents promptly. Accidents, incidents and corrective actions are discussed at staff meetings as evidenced in meeting minutes. There was evidence of hazard identification forms completed when a hazard is identified and that hazards are addressed, and risks minimised. A current, annually updated hazard register was available. Hazards are reviewed and discussed at each monthly health and safety meeting, as seen in minutes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	FA	<p>Ohinemuri BCM confirmed on interview they are aware of situations which require the facility to report and notify statutory authorities. These situations are reported to the appropriate authority via the Oceania support office staff. Since the last audit, there was evidence of 2 pressure injuries that had been reported to the Ministry of Health under section 31 of the Health and Disability Services (Safety) Act 2001.</p> <p>Staff training records reviewed confirmed that staff receive education on accident/incident reporting processes: at orientation and as part of the ongoing training programme. Staff interviews confirmed their understanding of the</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>adverse event reporting process, and their obligation to document all untoward events. Reporting, management, and closure of adverse events is completed on an electronic system. A review of electronic records confirmed staff documentation of any adverse, unplanned or untoward events, and sign-off by the BCM or CM.</p> <p>Review of accident/incident reports evidenced assessments and observations completed post accidents/incidents when appropriate. Corrective actions arising from accidents/incidents are implemented. There was evidence of corresponding notes in the residents' electronic records and notification of the resident's family members where appropriate. Family and residents' interviews confirmed the notification of next of kin where residents have had an accident/incident or a change in health status.</p> <p>Accident/incidents data and trends are graphed, analysed, and benchmarked against other Oceania facilities. Staff interviews, and monthly staff meeting minutes, confirm that specific learnings and results from accidents/incidents are shared at monthly staff meetings and inform quality improvement processes.</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, as well as accountabilities, responsibilities and reporting lines.</p> <p>The sample of staff files reviewed demonstrate that recruitment processes include: reference checks; police vetting; identification verification; a position specific job description; drug screening, and a signed employment agreement.</p> <p>There are systems in place to ensure currency of annual practising certificates and practitioners' certificates. Current certificates were evidenced for all staff and contractors that required them.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. Interviews with health care assistants (HCA) confirmed that they are supported by experienced staff members until competent in personal care provision.</p> <p>The organisation has a documented mandatory annual education and training module/schedule specific to each role, that includes topics relevant to all services and levels of care provided. There are systems and processes in place to ensure that all staff complete their required mandatory training modules and competencies. Health care assistants complete the New Zealand certificate of health and well-being. The 13 HCAs who work in the dementia unit have completed the 4 career force dementia unit standards, as evidenced in documentation reviewed.</p> <p>The CM and three other RNs have completed interRAI assessment training and competencies. Care staff complete annual competencies and knowledge, for example: hoist use and medication management. Education session attendance records evidenced that ongoing education is received and is relevant to the service. Staff interviews and review of training records, indicated that all staff, including RNs, undertake at least eight hours of relevant education and training per year.</p>

		An annual performance appraisal schedule is in place. All staff files reviewed evidenced completion of annual performance appraisals.
<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>	FA	<p>The organisation's staffing policy provides guidance to ensure staffing levels within the facility are sufficient to meet the residents' acuity needs and the minimum requirements of the DHB contract. Staffing levels are reviewed to accommodate anticipated workloads, identified numbers of residents, and skill mix needed. Staff have access to their rosters at least four weeks in advance. Casual and part time staff are available for extra rostered duties when required.</p> <p>There are 71 staff employed in the facility, including the management team, administration, clinical staff, activities staff and household staff. There are sufficient RNs and HCAs available to safely maintain provision of residents' care. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy type.</p> <p>The BCM and CM, who are RNs, are on duty during the day Monday to Friday. The hospital wing has one RN rostered on each morning, afternoon and night duty seven days per week. The hospital wing has four HCAs rostered in the morning, three in the afternoon and one at night.</p> <p>The rest home wing has four HCAs in the morning, three in the afternoon and one at night. The dementia unit has two HCAs in the morning, two HCAs in the afternoon, and one HCA at night. There is always at least one HCA in each area with current medication competencies. When the general practitioner (GP) completes a routine visit of the facility, an additional RN is rostered on to ensure cover on the floor should an RN be required to support the GP.</p> <p>There are village units near the facility. Interview with the BCM identified that facility staff were available to provide advice, however, RNs do not provide services to residents in village units. In case of an emergency, ambulances are called to attend village residents if needed.</p> <p>The CM and the BCM are rostered on call after hours seven days a week.</p> <p>Observation of service delivery confirmed that resident needs are met in a timely manner. Resident and family stated in interview, that staffing levels meet the residents' needs. Staff interviews confirmed that they have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that</p>	FA	<p>There are policies and procedures to guide medication management including prescribing, dispensing, administering, review, storage, disposal and reconciliation. Ohinemuri staff use an electronic medication management system.</p> <p>Resident records evidenced three monthly review by the GP or more often if needed. Medications are supplied by</p>

<p>complies with current legislative requirements and safe practice guidelines.</p>		<p>the pharmacy. There is a system in place to manage the return of expired or unused medications to the pharmacy.</p> <p>Review and observation of the storage and management of medication included review of the drug register. Weekly checks and six-monthly pharmacy checks were completed as required. Fridge temperatures are recorded weekly. Fridge contents observed were limited to medicines only. Interviews with staff confirmed no vaccines were stored on site.</p> <p>Medications are administered by both medication competent HCAs and RNs. A midday medication round was observed and evidenced practice in line with legislation, protocols and guidelines. The electronic medication management system in use was seen to facilitate timely and detailed recording of medicine administration information.</p> <p>There was one resident self-administering medication during the on-site audit. A process is in place to ensure ongoing competency of the resident and this is authorised by the GP. Secure storage was provided for this resident.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There are seasonal menus which have been reviewed by a dietitian.</p> <p>Kitchen staff interviewed are aware of the system and process to manage special diets and new admissions. Sufficient specialised plates, cups and cutlery was available to meet resident's requirements should they require additional support.</p> <p>Ohinemuri had undergone a food control plan verification in March 2020. Staff interviewed reported there had been no non-conformities. A relieving chef from another Oceania facility was on-site during the audit and was supported by kitchen staff. The relieving chef was responsible for ordering food from local suppliers. Food is prepared and served by the kitchen staff. The kitchens storage, freezers and fridges were sighted and met requirements. Food was covered and dated. The kitchen was observed to be clean and food was stored appropriately.</p> <p>Satisfaction surveys are completed and include questions related to food. Residents during interviews were complimentary around the food service, the variety and quality of food provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	<p>PA Low</p>	<p>Observations and staff interviews confirmed the facility has sufficient resources and equipment to meet the needs of residents, for example, wound care products and continence products. There was evidence in records reviewed specialists from the DHB were contacted where needed, such as wound care specialists.</p> <p>The GP interview identified they provide medical support across the week and are regularly on site four days a week. Progress notes are maintained.</p> <p>The PCCPs include documentation to guide staff in meeting each resident's needs, however, not all relevant</p>

assessed needs and desired outcomes.		information or interventions were consistently recorded in the electronic resident's record.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Ohinemuri provides activities programmes across all three levels of care each day. Separate programmes are provided for rest home residents, under 65s, residents in the dementia unit and residents at hospital level care. There are three activities coordinators available to facilitate the programmes across the week.</p> <p>Activity attendance is recorded each day and activity plans updated and entered into the resident's record. In all records reviewed, the residents' activities information was up to date and relevant to the residents' needs and preferences. Evaluations were current and documented. General activities provided reflect the interests of the residents and range of physical abilities as observed during the on-site audit and through review of the activities programmes.</p> <p>Community outings are arranged for groups and any resident can choose to attend. Café visits and men's groups are also available. Staff interviewed were aware of the activities programme and plans, and how to support activities within the facility at times when the coordinators were off site.</p> <p>A day respite service is facilitated during the week and participants take part in the rest home activities programme. Residents and family interviewed identified they enjoyed the additional company provided.</p> <p>In addition to the formal planned activities, activity boxes are supplied daily to the dementia unit. The boxes contain a variety of activities for staff to stimulate residents' interests. Residents in the dementia unit had 24-hour activities plans. Staff interviewed described a genuine affinity for supporting residents in this area of care.</p> <p>Residents interviewed discussed their enjoyment and suitability of the programme provided, and the company gained from group activities. Family members discussed a level of satisfaction with the activities and diversions provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated at each shift and documented in the progress notes as sighted in resident records reviewed. Progress notes sighted evidenced RNs review and sign off HCA's entries, as well as document additional nursing evaluations to measure progress against desired outcomes.</p> <p>InterRAI reassessments are completed six monthly or more often if required. Documented PCCP reviews occur six-monthly or sooner if required following reassessments (refer to 1.3.6.1). Where progress differs from the expected, this is documented in the progress notes and where needed a short-term care plan is developed. Short-term care plans were observed in response to wounds and residents falls. Short-term care plans reviewed were signed off when the issues were resolved or added to the PCCP if ongoing.</p> <p>Resident and family input into evaluation was recorded in the residents' PCCPs reviewed.</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>	FA	<p>There is a current building warrant of fitness displayed at the entrance to the facility.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The facility has an infection prevention and control (IPC) programme to guide staff in the identification, surveillance and management of infections. There is an identified IPC nurse with documented roles and responsibilities.</p> <p>Surveillance data is collected in the clinical areas by the IPC nurse and collated monthly by the CM for Oceania benchmarking. Information following benchmarking is provided to staff through staff meetings and throughout the facility from a dedicated IPC notice board as sighted during the on-site audit. Family and residents are updated through newsletters, resident meetings or directly by phone, email or text if required. This was confirmed by interviews with family and residents. Seasonal infection prevention information is available to residents, staff and visitors.</p> <p>Covid-19 information is available to all visitors to the facility. During the time of the on-site audit, it was observed staff were providing face to face information to each visitor and family on entering the facility. Oceania Covid-19 information and Ministry of Health information, was accessible (sighted) at the facility. The IPC nurse stated IPC resources are readily available should a resident infection or outbreak occur. In discussion with the IPC nurse, no outbreaks or resident requirements for isolation were identified since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Ohinemuri staff are guided by an Oceania restraint minimisation and review policy. The safe care and management of residents undergoing restraint is provided within the annual training programme. New staff interviewed had completed restraint competency as per orientation requirements.</p> <p>Staff interviewed were aware of the risks involved when restraint was used. Staff discussed the types of restraints available and the difference between restraints and enablers. Staff confirmed enablers are used at the request of a resident and are the least restrictive option.</p> <p>There were no restraints or enablers in use at the time of the on-site audit.</p>

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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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Staff interviewed reported current interventions to contribute to meeting residents assessed needs. Residents confirmed during interview that care is delivered in a manner that supports and respects their individual needs.</p> <p>The rest home level care tracer resident did not have all medical diagnoses or requirements related to fluid restrictions documented in the electronic resident record. At the time of the on-site audit, the facility added the required medical diagnoses and fluid restriction information to the resident's records. The resident was self-managing their own treatment for a chronic condition and when this was completed this was documented in the progress notes. There was no information related to the treatment or records maintained of self-management of treatment. A form was developed to document information related to self-treatment during the on-site audit.</p> <p>The sample size was extended to review interventions documented in the residents' records to contribute to meeting assessed needs and desired outcomes. A resident with weight loss over a six-month period was identified in the extension of the</p>	Not all interventions reflect individual resident needs as sighted in electronic residents' records reviewed.	<p>Provide evidence interventions are reflected in the electronic residents' records.</p> <p>180 days</p>

		sampling, however, there were no interventions documented to address the weight loss.		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.