# Oceania Care Company Limited - Takanini Lodge

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Takanini Lodge

**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: 28 July 2020 End date: 29 July 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:** 83

# 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 |
|  | 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

Takanini Lodge is part of Oceania Healthcare Limited. The facility is certified to provide services for 90 residents requiring rest home, hospital or dementia level of care. There were 83 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 residents, family, management, staff, and a general practitioner.

There was an area requiring improvement identified relating to complaints management.

## Consumer rights

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

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 are 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 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.

## 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 this facility. The vision, mission and values of the organisation are documented and communicated to all concerned.

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

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

The business and care manager 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.

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

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| --- | --- | --- |
| 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 business and care manager has primary responsibility for managing entry to service with support from the clinical manager and registered nurses.

Residents receive services from staff who are suitably qualified and experienced. InterRAI assessments are completed as required. The initial assessments and initial care plans are conducted within the required timeframes. Long-term care plans are documented and reflect resident current needs. The residents and family members contribute to development of care plans and multidisciplinary evaluation of care.

Medication policies reflect current legislation, protocols and guidelines. Medicines are managed in line with legislation and guidelines. Registered nurses and senior health care assistants are responsible for the administration of medicines and complete annual medication competencies and education.

The diversional therapist provides two activities programmes, one for rest home and hospital residents and one for residents with dementia. The activities programmes include meaningful activities that meet the needs of the residents. Special consideration is given to younger people with disabilities when planning the activities programme.

At Takanini Lodge all meals are prepared on-site. Residents individual food preferences, dislikes and dietary requirements are catered for. There are 24-hour snacks available.

## Safe and appropriate environment

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

There is a current building warrant of fitness 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 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

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| --- | --- | --- |
| 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 comply with the standard for restraint minimisation and safe practice. The restraint minimisation programme defines the use of restraints and enablers. Restraint minimisation is overseen by the clinical manager and restraint coordinator. The service has a current restraint register. There was one resident using restraint and there were no enablers in use on the days of audit.

## Infection prevention and control

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| --- | --- | --- |
| 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 appropriate for the size, complexity and degree of risk associated with the service. The service provides an environment which minimises the risk of infections to residents, staff and visitors.

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

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

Specialist infection prevention and control advice is accessed from the district health board; microbiologist, general practitioners and infection control specialists as required.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 49 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 100 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | 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).  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; involving family and residents in decision making; and ensuring residents are able to practise their own personal values and beliefs.  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 and family interviews confirmed that they receive information relevant to their needs. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | 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.  The policy ensures that all residents or their family/enduring power of attorning (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.  The information pack provided to residents and family on admission includes information regarding informed consent. The BCM discusses informed consent with family and the resident during the admission process to ensure understanding. Resident files reviewed demonstrated that informed consent was obtained.  The facility has surveillance closed-circuit television (CCTV) cameras in the corridors and entry/exit doors. A notice advising staff, residents and visitors of the presence of CCTV cameras in the facility, was put in place at the time of the audit.  Staff receive orientation and training on informed consent and staff interviews confirmed they are aware of the informed consent process.  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 for all residents in accordance with policy. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | There is an advocacy policy and procedure for staff to follow to ensure that residents and their families have a right to be represented and express views or concerns about their situation. It includes making them aware of the availability of advocacy services and supports access to advocacy services.  Information regarding the availability of the Nationwide Health and Disability Advocacy Service is included in the information pack provided to residents and family on admission. The complaints policy also includes making residents aware of their right to advocacy when making a complaint.  Interviews with residents and family confirmed that they are aware of the right to advocacy. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | 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, as well as observation, confirmed that families are welcome in the facility and were free to visit at any time.  Interview with residents, families and staff confirmed that residents are free to leave the facility and do so to be involved in such events as visiting local clubs and shopping trips. The activities programme, and the content of care plans include outings in the community. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The service has a complaints policy to support staff to manage complaints in line with Right 10 of the Code. Residents and families are aware of the complaint process and can access information if they want to make a complaint. Information on advocacy and complaint is provided at time of admission, including written information for the residents and families in the dementia unit. The complaint process guidelines, complaint forms, and a secure complaint and compliment box were accessible in the facility.  The facility BCM demonstrates knowledge of responsibilities and timeframes involved in the management of formal written complaints. Residents and families stated that their verbal complaints were resolved to their satisfaction in a timely manner. However, there was no evidence of verbal complaints being documented.  A complaints’ register and associated complaint forms are completed and current for the written complaints, including investigations, outcomes and communication progress date.  There has been one complaint to the Health and Disability Commission which is now closed. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | New residents and their families are provided with information about the Code as part of an information pack provided on admission to the facility. The business and care manager (BCM) or the administrator explain the Code to the resident and family during the admission process to ensure understanding.  The Code is also displayed on posters in the facility in both English and te reo Māori.  Information on the Nationwide Health and Disability Advocacy Service is available in brochures within the facility. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The organisation has 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.  Resident, family and staff interviews, and observation confirmed that: staff knocked on bedroom and bathroom doors; announced themselves; the reason for attending and request permission prior to entering a room; ensured that doors were shut when personal cares were being provided and residents were suitably attired and covered when taken to the bathrooms. Staff interviews, and observation confirmed that resident confidentiality was maintained. Resident and family members interviews confirmed that resident privacy was respected.  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.  Review of residents’ files and satisfaction surveys, and staff, resident and family interviews confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented and upheld.  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, resident and family interviews. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The organisation has a Māori health plan/policy that demonstrates Oceania Healthcare Limited (Oceania) commitment to ensuring residents who identify as Māori have their needs met in a manner that respects and acknowledges their individual and cultural values and beliefs. There is also a culturally competent services policy that describes for staff how culturally competent services should be delivered.  Interview with the BCM confirmed that support for staff for providing culturally appropriate care, and for Māori residents and their families, would be sourced if required through a local marae when required. Staff receive training in cultural safety and values at orientation and as well as part of the mandatory annual education programme. Staff and resident interviews confirmed that Māori cultural protocols were respected and upheld.  Family are invited to attend the resident’s multidisciplinary team (MDT) meeting and staff interviews confirmed awareness of the importance of involving whānau in the delivery of care. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services provided.  Information gathered during assessments includes identifying a resident’s specific cultural needs, spiritual values, and beliefs, as well as spiritual and cultural preferences such as church services. This information informs activities that are tailored to meet identified needs and preferences.  The spirituality and counselling policy ensures access for residents to a chosen spiritual advisor or counsellor where requested. For residents who choose to attend, there is a weekly Catholic church service, as well as a weekly Presbyterian church service. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There is a 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.  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, abuse and neglect, harassment and exploitation.  There were no documented complaints or incidents recorded since the previous audit relating to any form of discrimination, coercion or harassment.  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. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The facility implements the 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.  Training programmes are provided to all staff that include: the implementation of policy and procedures, good practice and service delivery.  The facility data is entered onto the Oceania electronic database and benchmarked against other Oceania facilities. The regional clinical and quality manager (CQM) reviews all data monthly. The CQM visits the facility monthly and reviews and discusses clinical indicators and performance measures. 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.  Staff, resident and family interviews, residents’ file notes and observation of service delivery confirmed that resident care was based on good practice guidelines. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy guides staff to report unexpected events that can compromise the care received by residents. This includes notification of relatives as a support person. Interviews with health care assistants (HCAs) confirmed an environment of open communication and where a ‘no blame’ culture supports the disclosure of incidents to residents and families.  Multidisciplinary team meetings enable families to participate in care planning and are scheduled six monthly or more often if needed. There was documented evidence of resident and family participation in MDT care planning. Interviews with families established that they receive regular updates on the residents’ care progress.  Resident meetings occur monthly, as evidenced by meeting minutes and resident interviews. A two-monthly facility information newsletter is sent to families.  Access to interpreter services and bilingual information for residents is available to residents and families through the local district health board (DHB) as per Oceania national policy. Facility staff are available to support interpretation for residents and families. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Takanini Lodge is an Oceania aged-care residential care facility.  The facility BCM reports monthly on a range of business and clinical performance indicators via an electronic platform. Data is collated at a national level, with sighted dashboards available to the regional teams who report to the executive management team and Oceania Healthcare board. The regional CQM was interviewed on-site during the audit. They demonstrated their support to the facility management and consideration of the trends and recommendations identified. The CQM pays routine on-site visits to the facility in addition to ongoing remote support and was observed assisting the facility manager and clinical manager (CM) as required during the audit. The BCM acknowledged their accountability for the implementation of quality improvements and appropriate services delivery by the facility.  The BCM is a registered nurse (RN) who has been in the role since 2017 and has six years’ previous experience as a CM with Oceania. The CM has held this position for three years and prior to this practiced as a RN at the facility. Both managers have current practicing certificates.  The service provides rest home, hospital and dementia care for up to 90 residents. The facility is certified for 21 dementia level beds, 48 hospital level beds and 21 rest home only beds.  At the time of the audit, there were a total of 83 residents, 23 receiving rest home level care, 40 receiving hospital level care, and 20 receiving dementia level care. The service holds contracts with the DHB for aged-related care, respite care and long-term support-chronic health conditions (LTS-CHC). At the time of audit, there was one young person with disability (YPD) assessed at rest home level care under LTS-CHC agreement. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | As per policy, the BCM indicated they delegate their management responsibilities to the CM during a temporary absence. Cover for the CM’s leave is ensured by a senior RN or a less experienced RN under the BCM’s supervision. The CQM is available to support the facility management during short-term absences and would organise a qualified relief manager from the Oceania group to cover a prolonged absence, should this arise. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation’s quality improvement policy supports a quality and risk management system that follows continuous quality improvement principles. The quality improvement system is executed at facility level by the monitoring, analysis, planning and implementation of corrective actions. Quality outcomes are brought together in monthly quality improvements meetings where they are discussed by the BCM with staff representatives from each service department.  Takanini Lodge adheres to Oceania’s organisation-wide policies and procedures that are current. A document control policy is in place. On interview, the BCM confirmed that staff are informed of policies and procedures through staff communications.  A planned schedule of internal audits was reviewed. Internal audits sighted identify the facility’s performance against key components of services delivery and were completed as per plan. Continuous monitoring and reporting of clinical indicators occur.  Data sighted evidenced monitoring, analysis and reporting for quality improvement purposes. Quality improvement information is shared with staff through meeting minutes displayed in the staff room as observed. Resident satisfaction surveys are performed twice a year and included in audit reporting. Results confirmed satisfaction with service provision.  Corrective actions’ reports are developed and implemented for any quality gap identified. Sampled reports were observed to be completed and indicated the person responsible for the actions, timeframes, review and evidenced sign off.  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 are discussed at health and safety meetings. There are two nominated and elected health and safety representatives.  Hazard reporting forms and staff interviews confirmed that hazard reporting is promoted. There was evidence that identified hazards are addressed promptly and risks minimised. A current hazard register is available with a section reviewed at each monthly health and safety meeting, to ensure that all hazards are reviewed at least annually. Hazards such as painting in progress, are sign posted with associated hazards identified. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The BCM is aware of specific situations that require notification to the correct authority regarding visitors, staff, residents, systems and property as per policy and regulatory obligations. There have been no events requiring essential notification since previous audit.  Review of incident reporting indicated that whenever possible families or emergency contacts are informed of unanticipated events and changes in a resident’s clinical condition. The general practitioner (GP) was notified when required. Staff interviewed confirmed that clinical incidents/accidents are reported to the RN in charge in a timely manner.  A sighted hardcopy register is used to record non-clinical incidents/accidents and notifications to appropriate stakeholders were sighted for these.  There is an electronic system to record and report all resident clinical incidents/accidents that are unplanned, untoward or a near miss. The incident reporting system links to the quality management system.  Clinical incidents/accidents reviewed evidenced documentation and sign off by the CM. Associated progress notes recorded the detailed interventions commenced. Neurological observations were completed for unwitnessed falls and suspected head injuries as per best practice. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources management practices follow an existing staffing policy which adheres to the principles of good employment practice and the Employment Relations Act 2000. The review of staff records confirmed the organisation’s policy is consistently implemented and records are maintained across the different categories of employees. Registered nurses and health professionals requiring practicing certificates had current practicing certificates in the staff files reviewed. Relevant qualifications were sighted for: the physiotherapist; the podiatrist; the dietitian; the chef and the GP. Personnel involved in driving the van held current driver licences.  The recruitment process involves police vetting, references checks and a signed contract agreement with a job description.  There was recorded evidence of staff receiving an orientation specific to their roles with a generic induction component. Appropriateness of orientation programme was verified in interviews. Annual performance appraisals were sighted in all staff files reviewed where appropriate.  An annual education plan organises the minimum regulatory eight hours of professional development for nurses, other clinical and non-clinical staff.  Staff competencies and education scheduled are coherent with the needs of aged-care residents, YPD and people receiving dementia care.  There are 10 trained interRAI nurses, and one RN undergoing training. Health care assistants who work in the dementia unit undertook necessary education credits in the required timeframes. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A base roster designed to meet all residents’ services needs with appropriate skill mixes and staffing levels 24 hours a day, 7 days a week is in place. The roster meets aged-care contractual requirements. Extra nursing support is provided Wednesday to Sunday in the midday period to help with nursing administrative tasks and routine communication with MDT and families. Each wing of the facility has a staff with a current first aid certificate across all shifts.  Seven days a week, there are at least two RNs in the two mixed hospital/rest-home wings on the morning and afternoon shifts, and there is one RN at night across both wings. Thirteen HCAs with a mix of long and short shifts are rostered in the morning in those two wings, seven in the afternoon, and two HCAs at night do a full shift.  The dementia unit has one RN and two HCAs Monday to Friday in the morning, and three HCAs in the morning Saturday to Sunday including one medication competent HCA. There are two HCAs in the afternoon, and two HCAs at night in the dementia unit seven days a week. RNs posted in the hospital/rest-home wings provide assistance to the dementia unit as required.  The BCM and CM are rostered on call after hours. Staff absences are covered internally, and on occasion, agency staff are used as reported by the CM and as confirmed in the rosters observed.  There is an organisation staged plan to mitigate the risk of a pandemic that includes collaboration between the head office and the facility to put into place supernumerary staff if needed. This is to reinforce current staff skills to manage the situation in accordance with the Ministry of Health and DHB guidelines.  Families and residents on interview stated they were satisfied with care provided by staff. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Residents’ records and medication charts are managed electronically. Residents’ information, including progress notes, are entered into the resident’s record in an accurate and timely manner. The name and designation of the person making the entry is identifiable. Residents’ progress notes are completed every shift, detailing resident’s response to service provision.  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. Electronic password protection and any hard copy information is 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.  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.  The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The Needs Assessment and Service Coordination (NASC) assessments are completed for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the resident’s level of care requirements.  Prior to admission there is a comprehensive information pack and orientation provided to all residents and their families including residents with dementia. Review of residents’ files confirmed entry to service processes, ensuring compliance with entry criteria. Interviews with residents and family and review of records confirmed the admission process was completed by staff in a timely manner. Residents and family members interviewed stated they had received the information pack and had received enough information prior to and on entry to the service. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a policy that describes guidelines for discharge, transfer documentation and follow-up. Interview with the CM and review of files evidenced a copy is generated from the electronic record and is delivered via way of yellow transfer envelope. Residents and/or family/whanau are consulted and kept informed of any adverse event, transition, exit, discharge or transfer. All relevant information is documented and communicated to the receiving health provider or service. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medicines management policies and procedures provide guidelines to ensure safe medicines management practices. Medicines are managed safely and securely to meet legislation, protocols and guidelines. Medicines are provided by the pharmacy in a pre-packed delivery system. Staff complete weekly drug register checks and balances reviewed were correct. Registered nurses and senior HCA responsible for medicines management complete annual competency testing and education.  The facility uses an electronic system for medicines administration. Medication information recorded meets legislative requirements and guidelines. Allergies and sensitivities are documented. Identification is current. Interview with the CM and review of these records verify the CM utilises reports in the electronic medicine management system to support safe medicines management. Medication records are reviewed by the GP at three-monthly intervals or when the health needs of the resident require review of their medicines. Safe medicine management practice was observed during the lunch time medication rounds. Interview with the CM and review of records evidenced antimicrobial policy meets accepted guidelines, monitoring and compliance is maintained and any trends are reported at Health and Safety meetings.  At the time of audit one resident was identified with safe management of self-administration of medicines. Review of records evidenced self-administration competencies were completed and current. Younger persons are supported to self-administer medicines where appropriate.  There were no standing orders at the time of audit. There were no stored vaccines or evidence of cold chain accreditation. Interview with the CM confirmed RNs are currently completing vaccinator training and the CM is aware of the requirement for cold chain accreditation. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | At Takanini Lodge the chef oversees food provision. The chef is supported by a second chef, a cook and three kitchen hands. All kitchen staff have current food safety training.  There is a current, verified food control plan. Food, fluid and nutritional needs of residents are in line with recognised nutritional guidelines. There is a four weekly seasonal menu reviewed annually by a dietitian at organisational level. A nutritional profile is completed for residents on admission by the RN and a copy is provided to the kitchen. Food preferences and cultural considerations are documented. Special diets are catered for. Specialised crockery is available as required.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines, as verified during the on-site audit. Food is plated and served via a bain-marie straight to the dining room adjacent to the kitchen and via scan box to residents with dementia. The kitchen provides a tray service for residents to dine in their rooms, if required. Snacks are available 24 hours a day.  Interview with the chef and observation verified there is enough emergency food for four to five days for all residents and staff. The chef reported they had access to extra food supplies if necessary.  Residents and families interviewed reported they are satisfied with the food service. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service has a process in place where access is declined, should this occur. When residents are declined access to the service, residents and their family, the referring agency and the GP are informed of the decline to entry. The residents would be declined entry if not within the scope of the service or if a bed was not available. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | A care needs level assessment is completed by the NASC team prior to admission to the service. Residents’ needs are assessed and documented, reflecting data from a range of sources, including but not limited to: the resident; family/whanau; GP and specialists. The interRAI assessments are completed within contractual timeframes. These interRAI assessments are available to staff as sighted in all residents’ files reviewed on the days of audit. The interRAI assessment and risk assessments inform the PCCPs. Interviews with staff and review of records confirmed continuity of service delivery. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The RNs are responsible for service delivery planning. Individual health goals based on resident’s needs are identified through the interRAI assessment process and are documented in the long-term care plans. Short-term care plans are documented for all short-term/acute needs and are signed off once resolved or added to the long-term care plan. Review of files evidenced integration of records and continuity of care. Interviews and review of records confirmed residents and/or family/whanau are involved in planning and review of care. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The long-term care plans are based on residents’ assessed needs, goals and desired outcomes. The RNs complete care plans that include specific interventions for long-term and short-term problems. The RNs and HCAs follow the care plan and report progress against the care plan on each shift at handover. Progress notes record changes. Observation records are maintained. Family communication is recorded in the residents’ files. Medical documentation is current. The service maintains links with other service providers to ensure the resident’s needs are met. If external nursing or allied health advice is required, the RNs will initiate a referral for example, to the wound care nurse specialist, physiotherapist or podiatrist. The dietitian reported appropriate and timely referral is provided from the RNs.  Discussions with residents, family and staff confirmed care provided is consistent with the needs of the residents. Interviews with staff and observation confirmed staff are familiar with the needs of the residents. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is developed by a diversional therapist (DT). Two DTs and an activities assistant facilitate two separate programmes across seven days. There is one programme for hospital and rest home and one for residents with dementia where activities are planned and provided to develop and maintain the residents’ skills and interests. Younger person specific activities include but are not limited to: support with equipment for own interest and involvement with the local community.  Interviews with residents and families confirmed they are involved in the planning and review of activities and that they can make suggestions. Attending activities is voluntary. Interviews with staff and review of records confirmed resident’s needs are assessed by the DT in consultation with the RN. Files reviewed for residents with dementia evidenced a 24-hour assessment and social history is completed in consultation with residents and their family/whanau. Activities reflect the residents’ preferences and cultural needs. There is evidence of strong links with community. Residents who prefer to stay in their room can have one-on-one visits including: for example: reading; hand massage and MP3 to enable the residents to listen to music from their chosen genre. Residents can attend any of the activities. Activities include but are not limited to: musical entertainment; movies; outings; bowling tournaments; arts and crafts, visits to local places of interest.  Residents and families reported satisfaction with the activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The residents’ long-term care plan reviews are documented six-monthly or when the resident’s condition changes. Reviews were current for all files sampled with evidence of progress recorded against the resident’s goals. There are monthly reviews by the GP or sooner if required. Resident care is evaluated on each shift and reported in the progress notes. Short-term care plans are signed off once resolved or transferred to the long-term care plan if the problem last longer than 30 days.  Interviews with residents and family/whanau verified they are included and kept informed of any changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services in consultation with the resident and/or family/whanau. If the need for other non-urgent services is indicated or requested the GP, RN or CM sends a referral to seek specialist service provider input from the DHB. Referral forms and documentation are maintained on resident files. Referrals are followed up on a regular basis by the RN, CM or the GP.  Interviews with the residents and family and review of documentation verified they are kept informed of the referral process. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented policies and procedures 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. It was observed that the large external rubbish crates were uncovered and overflowing with refuse and discarded equipment. These were emptied before the conclusion of the audit. A current hazard register is available.  Current material safety data posters are available and accessible to staff in relevant places in the facility, such as 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.  Staff receive training and education in waste management and infection control as a component of the mandatory training.  Interviews and observations confirmed that there is enough PPE and equipment provided, such as aprons, gloves and masks. Interviews confirmed that the use of PPE is appropriate to the recognised risks. Observation confirmed that PPE was used in high-risk areas. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation.  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 on a maintenance log sheet. These sheets are collected and reviewed daily by the maintenance person and attended to as required. A review of maintenance requests confirmed that requests were actioned and signed off. Interviews confirmed staff awareness of the processes for maintenance requests and that repairs were conducted in a timely manner.  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 hoists 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. Staff interviews and documentation evidenced that those staff who drive the van have a driver’s licence and complete van driving and competency assessments.  Hot water temperatures are assayed monthly. 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 temperatures re-assayed to confirm that they are within recommended temperature range.  All resident areas can be accessed with mobility aides. There are accessible external and external courtyards and decks. The dementia unit has a secure internal courtyard. All external decked areas have outdoor seating and shade and can be accessed freely by residents and their visitors. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are a mixture of resident rooms with their own ensuites and rooms that 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.  Communal toilets have a system to indicate vacancy and have disability access. Visitors’ toilets and residents’ toilets are located close to communal areas. All shower and toilet facilities have call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and to promote independence.  Residents were observed being supported to access communal showers in a manner that was respectful and maintained the resident’s dignity. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Residents have their own room, and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. There are eight rooms used for rest home only residents. All other 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.  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.  There are designated areas within the facility to store equipment such as wheel chairs, walking frames, commodes and hoists, tidily. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a dining room, next to the kitchen, in the rest home/hospital wing and one in the dementia wing. There are five lounge areas throughout the facility, as well as a number of small nooks with seating. 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.  There are areas for storing activities equipment and resources. There are areas in each wing, including lounge areas, that are used for activities.  Most residents were observed to have their meals with other residents in the communal dining rooms but can have their meal in their own room if they wish. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Facility laundry service, including residents’ personal clothing, is completed off-site at another Oceania 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 seven days a week. Interview with the laundry assistant confirmed that duties were confined to laundry functions only. Household staff interviewed confirmed knowledge of their role including management of any infectious linen. There was clear delineation of laundry in place. Signage for the clean and dirty entry in the laundry was put in place on the days of the audit. There is a washing machine and dryer in the laundry for occasional ad hoc laundry items. The dryer was re-sited to provide safe clearance from the wall on the days of the audit.  A cleaner is on duty each day, seven days a week and cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemicals on a trolley when cleaning and 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.  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.  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. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | 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. A RN is a nominated fire warden on each shift for each area.  The staff competency register evidenced that there is a system to ensure staff maintain first aid currency. In addition to RNs, there are at least two staff members on each shift with a current first aid certificate.  The facility has sufficient supplies to sustain staff and residents in an emergency situation. Alternative energy and utility sources are available in the event of the main supplies failing. These include: gas for cooking; emergency lighting; and enough food, water, dressings and continence supplies. The service’s emergency plan includes considerations of all levels of resident need.  All handbasins used for handwashing, including those in residents’ rooms, have access to flowing soap and paper towels. These were observed to be used correctly by staff and visitors.  Call bells are available to summon assistance in all resident rooms and bathrooms. Call bells and sensor mats are checked monthly by the maintenance person. Observation and family interviews confirmed that call bells are answered promptly.  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 lights and security cameras. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | 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 heat pumps and high mounted wall panel heaters in the winter. One low wall mounted heater was re-sited on the first day of the audit. The environment in resident areas was noted to be maintained at a satisfactory temperature. This was confirmed in interviews with staff, residents and families. Systems are in place to obtain feedback on the comfort and temperature of the environment.  The facility has a one designated external smoking area. Interview with the BCM advised that there is one resident who smokes. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Oceania has an established infection control programme. The infection control programme is reviewed annually and is current. The infection control programme, including its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. All infection control related issues are reported via the organisation’s incident reporting system.  The CM is the designated infection control nurse (ICN). There was a signed ICN job description outlining position responsibilities. The BCM, regional CQM and the Oceania infection control committee and infection control team provide support. Internal audits conducted include hand hygiene and infection control practices.  Visual information is located throughout the facility for visitors, staff and resident’s awareness of current safe infection control practices to minimise the risk of infection. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control team have completed relevant infection control education and have access to infection control nurse specialists and microbiologist at the DHB.  Observation during the on-site audit confirmed implementation of infection prevention and control procedures such as correct use of single use PPE and use of hand gels. Single use items for example, gloves, paper towels and hand gels are available throughout the facility. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual includes; a range of policies, standards, guidelines, definition of roles, responsibilities and oversight, training and education of staff. The infection control policies are current and reviewed as part of the document review process at organisational level. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control nurse completes annual training in infection prevention and control through updates at the DHB in January 2020.  The infection control nurse is responsible for providing education to staff in the facility. Infection control education for staff is provided at orientation, induction of new staff and ongoing training through the organisation’s annual education and training programme or at an ad hoc basis when required. Staff complete annual training days for infection control, handwashing and correct use of PPE. Interviews with staff and observation verified staff are aware of correct use of PPE. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Definitions of surveillance and types of infections are clearly defined and documented to guide staff. The surveillance is appropriate for the size and scope of services provided. All staff are required to take responsibility for surveillance activities. Interviews with staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal and written handovers and progress notes. This was evidenced attending handover and review of the residents’ files.  The service submits data monthly to Oceania support office where benchmarking is completed. Infections collated monthly include for example; urinary tract, eye, upper respiratory and skin. This data is analysed for trends and reported to the monthly infection control team meetings and disseminated to staff at the staff meeting. The CM reported interventions required for staff training or changes required at facility level are implemented. This was verified in review of meeting minutes. Meeting minutes are made available for staff.  Interview with the CM and review of documentation confirmed there were four suspected cases of norovirus reported to Regional Public Health since the previous audit. Results of testing was negative for the virus.  The CM reported the facility follows current Ministry of Health Guidelines regarding COVID-19. All staff complete education on handwashing and the correct donning and removal of PPE. During COVID-19 lockdown the infection control team met twice weekly with the Oceania infection control team. The CM reported ongoing support and links to the infection control team and health of older people team at the DHB during this time. Interview with the CM and observation verified there is a comprehensive plan in place including enough infectious control consumables, yellow waste containers, hand gels and PPE (including gowns, gloves, surgical masks) for all residents, staff and visitors (including visitor packs with hats, tops, pants and socks) in the event a staged COVID-19 management plan is required within the facility. A second outbreak kit has been added to the facility. There is a dedicated visitor’s room set up with social distancing procedures with screening of visitors and visiting time limits. The CM reported there is a visitor coordinator who is always present in this room. COVID-19 registers are maintained. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Oceania policy provides a definition of restraint and enabler use which is congruent with the definition in the restraint minimisation and safe practice standard. The facility actively minimises the use of restraint. There was one restraint (chair brief) and no enablers in use at the time of audit. The file reviewed for a resident using restraint evidenced a documented risk management plan.  Staff interviewed confirmed their understanding that enabler use would be voluntary and considered the least restrictive option. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The Oceania clinical and quality team are responsible for approving any form of restraint. The restraint coordinator is responsible for oversight of restraint use at the facility. A RN is the restraint coordinator. The signed position description highlights the responsibilities for this role. The restraint coordinator had completed relevant education in restraint minimisation and safe practice last in May 2020.  Review of the resident’s file evidenced assessment of the resident had been completed prior to the use of restraint. The approval includes consultation with the MDT. Interviews with staff and the GP confirmed restraint is only considered as a last resort. Review of staff records and interviews with staff confirmed ongoing education is provided regarding restraint minimisation and safe practice, enabler use and challenging behaviour. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The file reviewed for restraint use included documented assessment and consent that meet the criteria for this standard. Assessment included: identification of restraint related risks; underlying causes for the behaviour requiring restraint; existing advanced directive; history of restraint use; history of trauma or abuse the resident may have experienced; culturally safe practice; identification of desired outcomes and criteria for ending restraint and all possible alternatives to restraint use. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The use of restraint is actively minimised. Interview with the restraint coordinator confirmed that prior to the use of restraint all alternatives to restraint are considered and discussed with staff and family members. Alternatives include sensor mat, low-low bed, hourly rapid rounding and review by the physiotherapist. Staff confirmed their understanding regarding the use of restraint and how to maintain safe practice.  Assessment documents the reason for restraint use. Consent was signed by the GP, restraint coordinator and a family member. Monitoring forms were completed by the HCAs. Access to advocacy is facilitated where necessary.  Restraint use is documented in the long-term care plan. Evaluations are completed two-monthly by the restraint coordinator. A restraint register is maintained and reviewed at each restraint approval group meeting. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Interview with the restraint coordinator and review of documentation confirmed any episodes of restraint are evaluated at two-monthly intervals. Restraint in use at time of audit had two-monthly evaluations documented.  The restraint coordinator and RNs maintain communication with families regarding use of restraint. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint coordinator reports on restraint management at monthly meetings. Interviews with staff and GP confirmed that the restraint approval process is included in the medical review. Restraint reviews include: compliance with policy; effectiveness of restraint; adverse events related to restraint use; safety and cultural considerations. Quality reviews include staff knowledge and good practice.  The restraint minimisation and safe practice policy was last reviewed in June 2020 by the National Restraint Authority Group at organisational level. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | Complaint documentation demonstrated management of formal written complaints according to Right 10 of the Code. Since the last audit, all written complaints reviewed met Right 10 of the Code. Documented complaints generated investigations and corrective actions, with evidence of implementation. However, verbal complaints were not documented.  Residents and families interviewed commented that any complaint made was resolved in a timely manner. However, there was no documented evidence of management of verbal complaints or entries on a complaint register. | As per policy, and as per Right 10 of the Code, there was no evidence that verbal complaints were documented. | Ensure all complaints, including verbal complaints are documented.  180 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.