

Oceania Care Company Limited - Te Mana Rest Home

Introduction

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

The audit has been conducted by The DAA Group 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:	Te Mana Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 21 April 2021 End date: 22 April 2021
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:	44

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
Yellow	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
Red	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

Te Mana Rest Home provides rest home and hospital level care for up to 44 residents of which nine are young people with disabilities. The service is operated by Oceania Healthcare Limited and managed by a business and care manager, and a clinical manager. Residents and family/whānau members interviewed were appreciative and positive about the quality of care and support being provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family/whānau, management, staff and a nurse practitioner. For this audit, the lead was also the consumer auditor.

The audit resulted in a continuous improvement in relation to development of internal courtyards. There were no areas identified as requiring improvement.

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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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

Information on how to make a complaint is provided at the time of admission and is readily available at the front reception. A complaint and concerns register is maintained.

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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The motto and values of the organisation are promoted. Strategic, quality improvement, health and safety and risk management plans provide direction to the managers and team both at Te Mana Rest Home and at the support office. Effective monitoring reports on key performance indicators for both financial and clinical aspects of the services are regularly provided to specific managers in the support office.

An experienced and suitably qualified business and care manager manages the facility and is supported by a competent registered nurse, clinical manager.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and family/whānau. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

Human resources policies and procedures are being implemented according to legislative and contractual requirements. The appointment, orientation and management of staff are based on current good practice. Staff are supported to participate in a comprehensive range of training opportunities that meet mandatory requirements as well as their career direction, as relevant. Regular individual performance reviews are occurring. Staffing levels and skill mix support safe service delivery and meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

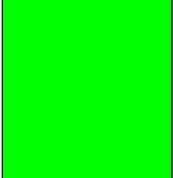
The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Policies and procedures guide staff management of waste and hazardous substances. Staff use protective equipment and clothing, which is readily available.

There is a current building warrant of fitness on display. Electrical and bio medical equipment are tested as required and hot water temperatures are safe. The building meets the needs of the residents, is clean and an efficient maintenance system is in place. External areas are accessible, safe and provide shade and seating.

Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken offsite and both laundry and cleaning processes are evaluated for effectiveness.

Staff are trained in emergency procedures and use of emergency equipment. There are sufficient supplies for use in the event of a civil emergency and fire evacuation procedures are regularly practised. Residents are satisfied with response timeframes for call bells. Security systems are maintained according to written procedures.

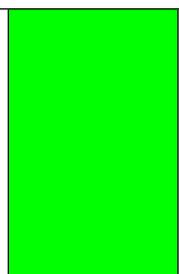
Communal and individual spaces have natural light filtering in and are maintained at a comfortable temperature.

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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Organisational documentation related to restraint minimisation and safe practice are accessible to staff. Three enablers and five restraints were in use at the time of audit. Assessment, approval, monitoring process and review processes are in place, as are reports through the quality improvement system. Staff are aware that enablers require the person's approval and described the training they receive on the use of restraints and enablers and the de-escalation of behaviours.

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.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	50	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Te Mana Rest Home is guided by Oceania Healthcare Limited's overarching policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed demonstrated knowledge, understood the requirements of the Code and were observed demonstrating respectful communication, open disclosure, encouraging patient independence, providing options and maintaining residents' dignity and privacy. The Code is a component of the staff induction process and included as part of annual training sessions, most recently held during a study day on 21 February 2021.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form.</p> <p>Advance care planning was sighted in the seven clinical files reviewed. Enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day-to-day care.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The CM said there had been no incidents where advocacy was required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy and residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families confirmed they could visit at any time and are always made to feel welcome. Residents are encouraged to be involved in community activities and to maintain family and friend networks. Regular shopping trips are part of the activities programme. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy covers people's right to make a complaint and has recently been reviewed to also include management of concerns. This adaptation was made in response to managers becoming aware that concerns were not being well captured to prevent an area of concern from escalating. The complaints policy and associated forms cover Right 10 of the Code and information on the policy is provided during the admission process. Residents and family/whānau members interviewed were aware of how to lodge a complaint. Complaint forms and information are available at the front desk at all times.</p> <p>Complaints are recorded into the organisation's computer system and managed by the business and care manager in consultation with support office team members as applicable. A complaint reporting severity matrix is now available for managers to use to assess the risk level of each complaint. Staff receive training on the complaints process annually.</p> <p>The complaints register reviewed showed there have been no formal complaints lodged since March 2019. During interview, the business and care manager informed that their open-door policy enabled people to express concerns informally at any time and this had potentially reduced the risk of a complaint being lodged. This person is aware of the change of policy and the need to lodge these into the concerns register going forward. Due to the length of time since the last complaint a review of follow-up of complaints was not undertaken. However, the quality, compliance and audit manager, and the business and care manager, described the processes around complaint investigation, action plan development and reporting. They also</p>

		<p>noted the need for the issues to be discussed at staff quality meetings and for them to be reported to the support office alongside any themes that were emerging. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The District Health Board (DHB) advised of two issues of concern. One of these dated back to January 2019, which the current business and care manager was not familiar with. The clinical manager provided evidence to confirm the changes made prior in August 2019 have been sustained. A second concern was for May 2020 and relevant registered nurse training has since occurred, alongside the clinical manager adopting a strong monitoring role for the review of assessments and ensuring changes are made to care plans when indicated. No other complaints have been received from external sources.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code is displayed in poster form in both the dining room and staff room. Information about the Code is provided in all new residents' information packs. The clinical manager (CM) discusses the Code with residents and their family on admission. Discussion relating to the Code is also included on the agenda and discussed at the residents' meetings. The interviews with residents and family members confirmed their rights are being upheld by the service. Information on the Code is provided to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. The posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Te Mana Rest Home (Te Mana) ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to individualise their rooms. Spaces are available for private conversations and patient information was maintained in the computer with staff having unique login to access. The residents and family members interviewed confirmed they were treated with respect. A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner, with strategies documented to manage any inappropriate behaviour if there are any issues for a resident. Health care assistants (HCA) were observed knocking on bedroom doors prior to entering, doors were closed when cares were been given. Residents and staff reported they had not witnessed any abuse or neglect; however, they understood the processes to follow in the event of this occurring. Staff receive annual training on abuse and neglect and can describe the signs. There were no documented incidents of abuse or neglect in the incidents reviewed in residents' files. Staff interviewed were aware of the need to ensure residents are not exploited, neglected or abused. Staff are clear about professional boundaries and ethics that inform their behaviour when interacting with residents. A staff code of conduct booklet was included in their orientation pack.</p> <p>All residents have access to a coffee machine to make drinks in a safe manner, for themselves and their visitors, to maintain their independence.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Māori health plan describes that the holistic view of Māori health is to be incorporated into the delivery of services. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. Access to Māori support and advocacy services is available through Aged Concern. A cultural assessment is completed as part of the care plan for all residents. Two residents identified as Maori and when interviewed said they had been asked about the inclusion of cultural beliefs in long term care plans (LTCPs) and had refused due to lack of personal interest. This was observed to be documented in their long-term care plans (LTCP). Cultural celebrations are included in the activities plan. Staff members also provide cultural advice and support for residents and staff, if required. There is a whānau room available for use by family members.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has appropriate policies and procedures to ensure the recognition of Māori values and beliefs and that of other cultures. Residents/family verified they were consulted on their individual ethnicity, culture, values and beliefs and staff respected these. Residents' personal preferences required interventions and special needs were included in the care plans reviewed. Staff are educated as part of the mandatory education provided on cultural safety and cultural appropriateness. An annual cultural day is held to celebrate the cultures represented. Church services are available to residents and their families.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. Staff training includes discussion of the staff code of conduct and professional boundaries. The staff are aware of the need to ensure unbiased fair care and treatment is provided regardless of the age, gender, religion, sexual preferences, ethnicity and/or social standing. Residents and family members expressed that care was provided in a respectful manner and they felt safe at Te Mana.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive</p>	FA	<p>The service implements Oceania policies to guide practice which are in line with the Health and Disability Services Standards. The organisation's quality framework includes their internal audit programme. Benchmarking occurs across all the Oceania facilities. There is an internal mandatory training programme for all staff. Staff reported they receive management support for external education and access their own</p>

services of an appropriate standard.		professional networks to support contemporary good practice and evidence-based practice. The interviews with residents and families expressed a high level of satisfaction with the care delivered. The clinical manager (CM) has delegated different areas to each registered nurse (RN) to ensure a high level of compliance to policies and procedures is maintained.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Interviews with residents, and/or family members confirmed they are kept informed about any changes to their own/the resident's health status and are notified in a timely manner of the results of any investigations and/or treatment outcomes. This was supported in the residents' records reviewed. There was evidence of resident/family input into the care planning process.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services are accessible by staff for residents. A multicultural staff has enabled communication with two residents who speak English as a second language. Te Mana has some non-verbal residents, and these residents have information in their care plans of actions/body language to observe for to indicate needs. A white board has been used to assist with communication as required.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Oceania Healthcare has just rebranded, and the new motto is 'strive for better'. Four values underpin this motto. Strategic direction documentation has a significant financial component and is supported by each facility having its own business plan. The framework for this was sighted and the 2021 version will be completed by the business and care manager alongside the regional operations manager during an upcoming scheduled visit. Meantime the business and care manager has a monthly meeting with the regional operations manager when they discuss the monthly report. Similarly, the clinical manager meets with the regional clinical manager to discuss a monthly report that has a clinical focus and includes updates on the pre-determined clinical indicators, risks and emerging clinical risks. There are monthly clinical governance committee meetings in addition to clinical team meetings. Reports and meeting minutes from each of these constructs were viewed and demonstrate adequate information to monitor performance is being reported through to the support office and back again as relevant. A review of clinical governance was undertaken February 2020 and the clinical excellence strategy that has since been developed is to be released 12 May 2021 (Nurses' Day).</p> <p>The service is managed by a business and care manager who confirmed during interview they are suitably experienced and hold relevant qualifications including a small business management diploma. Their personnel file confirmed they have worked for Oceania Healthcare for seven years and been in their current role for three and a half years. Responsibilities and accountabilities are defined in a job description and there is a signed individual employment agreement. Previous employment roles have included managing suppliers and contractors for a different type of industry and owning their own business for seven years. A performance review was undertaken by a line manager in June 2020. The business and care manager demonstrated</p>

		<p>knowledge of the sector and regulatory and reporting requirements and in January 2021 took on a supplementary role as manager of a retirement village at another Oceania site.</p> <p>The service holds age related residential care agreement (ARRC) contracts with the local District Health Board for rest home and hospital services, including respite care. It also has a contract with the Ministry of Health for the provision of residential services for young persons with a disability (YPD), including respite care. On the day of audit, there were 33 people receiving hospital level care, of which six were on the YPD contract. One hospital level care resident passed away on the morning of the audit. Eight people were receiving rest home care, of which one person is on the YPD contract. One other person is on respite care, plus two others have been on a short term respite care YPD contract for hospital level care for over two years. One of the people receiving hospital level care is partly funded under an Accident Compensation Corporation contract. The provider has a contract to provide care for people on a long term chronic care contract, although there was nobody on this contract at the time of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the business and care manager is absent, the clinical manager steps up and undertakes tasks under delegated authorities, including for signing. A senior registered nurse takes on the clinical manager's role. The Oceania regional clinical manager, or the regional operations manager, is available to assist as necessary and will address any more challenging issues that may arise. Staff confirmed there is always adequate support available or access to people who have the right information for a range of situations, including staff absence, property repairs and residents' incidents and deterioration, to mention a few.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes a review of resident care issues, internal audit results and corrective action reviews, updates on quality improvement projects, overview of incidents and accidents and of clinical indicators, infection control update, restraint reports, compliments and complaints, health and safety meeting updates, any policy changes, staff training, suppliers and contractors, food control and general issues. A quality, audit, compliance manager based at the support office oversees the organisation's wider quality and risk management system and Te Mana's business and care manager provides reports on the quality system through to this manager.</p> <p>Residents' meetings are held two-monthly. The managers take time to discuss satisfaction and issues of concern on a one-on-one basis with the younger people with disabilities and their comments are noted. In addition, there are monthly staff and quality improvement meetings, which are for all staff and are in addition to</p>

		<p>the separate monthly meetings the business and care manager has with cleaners, kitchen staff, maintenance, recreation/activities staff and with the health and safety team. Minutes of the staff and quality improvement meetings for each of the past three months confirmed verbal reports that the topics as listed above are consistently being reviewed and followed up. Data from a range of quality indicators is being analysed, trends or risks are being identified and followed up and corrective actions and quality improvement processes implemented as applicable. Staff confirmed that they attend the staff quality meetings or follow up on their messaging system for the minutes. They sign off on the system that they have read the meeting minutes if they were unable to attend.</p> <p>An internal audit schedule sees a range of audits allocated for each month. These audits are being completed and when indicated, corrective actions are developed and reported through the staff and quality improvement meetings. Examples of this process working were evidenced. There are two types of surveys, one being a six monthly survey for residents which activity staff or family/whānau members may assist them with. A second generates a net promoter score and compares results with other Oceania Healthcare facilities. Ideas had emerged from the latest results, but neither of the latest survey results provided sufficient information to identify a trend requiring specific change.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and those reviewed were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The business and care manager discussed the master facility risk profile register provided through the support office. This register is comprehensive. There was evidence in meeting minutes that additional site specific risks are being identified in a range of areas and these are monitored reviewed and mitigation strategies developed. Health and safety monthly meeting minutes were viewed and showed the latest was 27 April 2021. These covered reminders for staff about keeping themselves safe, updates about the current health and safety representatives, moving and handling and a report on the latest facility check. The business and care manager is familiar with the Health and Safety at Work Act (2015) requirements and several staff have completed relevant training. There have been two health and safety representatives, although this is due to change.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form direct into the organisation's intranet. Staff incident reporting and investigation forms, early notification of pain forms, risk assessment forms and hazard reporting forms are completed in hard copy and followed up and investigated by the business and care manager. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Records viewed confirmed adverse event data is collated, analysed and reported to the support office and through the monthly staff quality meetings. Corrective actions and quality improvement opportunities are developed and implemented as</p>

<p>where appropriate their family/whānau of choice in an open manner.</p>		<p>required with examples of this occurring sighted.</p> <p>An early notification of pain form is completed by staff when they experience pain resulting from actions taken during a shift. These are reviewed by the business and care manager and the person is assessed by a physiotherapist who visits each week. The physiotherapist also provides health and safety advice in relation to moving and handling to help prevent staff and resident injuries.</p> <p>The clinical manager who is responsible for essential notification reporting requirements, including for pressure injuries, described the process and the circumstances in which various events would be reported and to whom. They advised there have been no notifications of significant events, such as police investigations, coroner's inquests or infection outbreaks made to the Ministry of Health since the previous audit. Root cause analyses of such events are undertaken at the organisational level and reported through the quality and risk management system.</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 resources management policies and processes are based on good employment practice and relevant legislation. These note that all new employees are to complete an application form and undertake a formal interview with the business and care manager using the Oceania Healthcare interview form. Documentation requirements such as an application and qualifications are specified, as are checking processes that include two referees, police vetting and a drug screen. A sample of staff files verified these requirements are being consistently implemented and relevant documentation including signed employment agreements are completed.</p> <p>All new employees participate in the planned orientation, which includes all necessary components relevant to the role. Staff interviewed described the orientation process which includes being buddied with an experienced person for a minimum of two days, or as long as needed, and completing an orientation checklist within the first three months. A series of competencies such as moving and handling and infection control need to be verified. Copies of completed orientation checklists were in staff files reviewed. The business and care manager discusses their performance with them at three months and establishes training requirements.</p> <p>Oceania Healthcare's 'grow, educate and motivate' (GEM) training programme is being implemented annually and covers the mandatory training required to meet contractual requirements. Health care assistants have either completed or commenced a New Zealand Qualification Authority education programme. Fifty percent of registered nurses are maintaining their annual competency requirements to undertake interRAI assessments and another two nurses are in the process of completing their training. Records of annual performance appraisals demonstrate all were current. All staff have access to external training opportunities that follow their personal career pathway. Some of these staff contribute well to the younger people as they are pursuing training in topics including physical therapies and psychology. Additional level three certificate trained staff are also encouraged to do their diversional therapy to improve the lives of the younger people. Staff complete a series of competencies (clinical and non-clinical as relevant) every eleven months. All registered nurses, the</p>

		van driver, activities staff and senior healthcare assistants complete first aid training every two years. Staff training records are being maintained in a comprehensive electronic system, which when viewed confirmed the requirements as described above are being met.
<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>A staffing policy notes staffing will be reviewed at least annually and that staffing levels are variance managed related to occupancy numbers, resident dependency and resident acuity. Rosters reviewed confirmed staffing levels and skill mix are commensurate with contractual requirements and the provision of safe service delivery, 24 hours a day, seven days a week (24/7). The business and care manager confirmed they may alter staffing levels to cover periods of heavy workload after consultation with the regional clinical manager and regional operations manager. This may be initiated by registered nurses, in consultation with the clinical manager, to meet the changing needs of residents. Care staff confirmed there were adequate staff available to complete the work allocated to them and that any unplanned absence is always covered. Unplanned absences are covered by a casual staff person for Te Mana, or a staff person may choose to pick up an additional shift within their employment rules. No agency staff are used in this facility. Observations and review of a four-week roster cycle confirmed these reports and showed adequate staff cover had been provided.</p> <p>At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) registered nurse coverage. All registered nurses have a current medication competency. An activities person is also rostered on weekends. Residents and family/whānau believed there were generally enough staff on duty but sometimes staff do get busy.</p> <p>An afterhours on call roster for management support is in place and there is access to management advice from the support office if necessary. The business and care manager works in another of Oceania's premises one day a week when the clinical manager takes responsibility for the Te Mana facility.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered, at admission, with the involvement of the family. There is sufficient detail in residents' files to identify residents' ongoing care history and activities.</p> <p>Residents' files are electronically stored using eCase software that is password protected. Entries are legible, dated and signed by the relevant health care assistant, registered nurse or other staff member, including designation. Residents' files are protected from unauthorised access by each staff member having a unique login password. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</p> <p>Individual residents' files demonstrated service integration with input from the CM, RN and health care assistants (HCAs), diversional therapist (DT) and nurse practitioner (NP). Archived information is stored</p>

		appropriately for recommended time periods.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care. Interviews with residents and family and review of records confirmed the admission process was completed by staff in a timely manner and that they received sufficient information. The admission agreement defines the scope of the service, includes all contractual requirements and evidenced resident and/or family signature within the required timeframe.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	Exit, discharge or transfer is managed in a planned and coordinated manner. Staff accompany resident to appointments if required when family are not available. There is open communication between services, the resident and the family. At the time of transition appropriate information is supplied to the service or individual responsible for the ongoing management of the resident using the 'yellow envelope system'. Referrals are documented in the residents' progress notes. Relatives interviewed confirmed they are kept informed of the process.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe electronic system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage and undertake an annual competency training.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. Te Mana has two medication trolleys stored in a shared medication room. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the</p>

		<p>recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly NP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There was one resident who self-administered an inhaler at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. The NP had assessed the resident as competent and the medication was stored safely.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>	FA	<p>The food service is provided on site by a team of cooks and kitchen hands and is in line with recognised nutritional guidelines. The menu rotates over four weeks with summer and winter cycles and was approved by a qualified dietitian in March 2021.</p> <p>Dietary assessments are undertaken for each resident on admission and a dietary profile developed. Personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook. Special equipment, to meet resident's nutritional needs, was sighted. Residents' files demonstrated monthly monitoring of the individual resident's weight. Residents stated they were satisfied with the food service. Residents who are identified with weight loss have completed short term care plans and relevant interventions to monitor the weight loss. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and confirmed in the resident meeting minutes. A feedback form was available in the dining room for residents to inform kitchen staff and responses documented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal, complies with current legislation and guidelines. A hot box is utilised for delivering meals to residents' rooms. The service operates with an approved food safety plan and registration issued by Ministry of Primary Industry which is current until March 2022. Approved food handling certificates were sighted for all kitchen staff. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan.</p> <p>Residents were observed to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner. The kitchen provides food for celebrations and 'theme days'.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the</p>	FA	<p>There is a process in place to inform residents and family of the reasons why services had been declined, should this occur. When residents are declined access to the service, residents and their family, the referral agency and/or the GP are informed of the decline to entry. The residents would be declined entry if not within</p>

service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		the scope of the service or if a bed was not available. The CM gave an example of a resident who was declined due to specialised nursing input that was not available at the time.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents' needs, outcomes and goals are identified through the assessment process. Assessments are recorded, reflecting data from a range of sources, including the resident, family and GP. Assessment tools include, pain scale, nutritional screening, mobility, cognition, falls risk and skin condition. The assessments are conducted in a safe and appropriate environment, usually the resident's room. Interviews with residents and family confirmed their involvement in the assessment process. All residents have a current interRAI with outcome scores reflected in the care plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Residents' care plans are individualised, integrated and up to date. Recorded interventions reflect the risk assessments and the level of care required. InterRAI assessments are completed by RNs and inform the person-centred care plans. The short-term care plans are developed for the management of acute problems, when required, and signed off by the RN when problems are resolved. Interviews with residents confirmed they have input into their care planning and review. HCAs interviewed confirmed that they are included in the care planning process. The young people with disabilities had current outcomes assessments on file specific to their needs.
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 residents' care plans evidence interventions based on assessed needs, desired outcomes or goals of the residents. Interviews with residents and families confirmed care and treatments meet the residents' needs. Staff interviews confirmed they are familiar with the needs of the residents they are allocated to by reading the care plans and are informed of changes during shift hand overs. Family communication is recorded in the residents' files using a tick box as part of the electronic system. The NP interviewed confirmed that medical input is sought in a timely manner, that medical interventions are completed, and that safe care is provided by the staff. A range of equipment is available suited to the needs of the resident and level of care provided, including air mattresses, bedrails and specialised wheelchairs.
Standard 1.3.7: Planned Activities	FA	The activities programme is provided by one trained diversional therapist, holding the national Certificate in Diversional Therapy, two activities coordinators and rostered volunteers. A volunteer drives the van on

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>Mondays and Fridays. Outings occur both morning and afternoon on these days.</p> <p>A social assessment and life history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated by observing engagement and as part of the formal six monthly care plan review. Resident meetings are held monthly to provide feedback and for residents to give ideas for future activities.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities, gender specific activities and regular events are offered. Residents interviewed confirmed they find the programme varied. "I Love Music" is an Oceania programme which has been utilised with residents who prefer to remain in their rooms or a more passive participant due to special needs.</p> <p>There is one activities programme for the rest home and hospital residents and all younger people with disabilities have specific activities added to their activities programmes to facilitate more social interaction with others, such as shopping trips, and outings. The residents' activities attendance records are maintained.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes. Change is noted and reported to the RN. Care plan evaluations and reassessments occur every six months or when the resident's condition changes. Where progress is different from expected the care plans were edited to reflect changes. Short-term care plans (STCP) are initiated for short-term concerns, such as, infections, wound care, changes in mobility and other short term conditions. STCP are reviewed daily, weekly or fortnightly, as indicated by the degree of risk noted during the assessment process. An STCP was observed for a urinary tract infection and a respiratory infection. The wound care plans evidenced timely reviews.</p>
<p>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.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Te Mana has a NP service who provide visits to the facility twice a week but residents may choose to use another medical practitioner if they wish. If the need for other non-urgent services is indicated or requested, the NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons mental health and a speech language therapist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. The service has a multidisciplinary team approach. Progress notes document contact with the families via a dropdown tick box. The NP confirmed residents and their families are advised of their options to access other health and disability services.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>A healthcare waste policy, which covers the management of medical waste, soiled disposable, wet linen, sharps and body fluids/waste is documented within the infection control policy. Contractors cover the recycling of plastics and cardboard, general waste and green waste. The organisation is increasing its vigilance around waste management and recycling processes, including for soft plastics. A hazardous substances register was sighted and covers the different types of chemicals stored, safety precautions of each and safety equipment required. Appropriate signage is displayed where necessary. Staff confirmed they follow these processes and were observed doing so.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Staff interviewed were able to direct the auditor to the material safety data sheets which were on display where chemicals are stored.</p> <p>There is provision and availability of protective clothing and equipment including disposable masks, face shields, plastic aprons and disposable gloves and staff were observed using these as applicable.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness with an expiry date 4 June 2021 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Hot water temperatures are checked monthly. Ongoing efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. These are monitored according to a series of checklists which are reviewed monthly. The records were up to date. Any repairs required are addressed in a timely manner and signed off when completed. The maintenance person expressed their commitment to maintain the place going and to make it a 'nice, pretty home' for the people who live at Te Mana. A transport policy is in place and the company van has a current warrant of fitness and registration.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting with sufficient room to move the motorised wheelchairs of the young people around. There is shade and shelter, especially on the two decks/internal courtyards, which have wings of the facility on all four sides of each. One of these is covered by an 'archgola' with ventilation around all four sides. A project that took these areas from being unsafe and unattractive courtyards to becoming pleasant decorative outdoor decks that are now frequently used has demonstrated positive outcomes for residents and a rating of continuous improvement has been allocated for criterion 1.4.2.6.</p> <p>Residents and family/whānau members confirmed they are happy with both the internal and external environments at Te Mana.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes one shower and toilet combination; two shared ensuites with a toilet and shower in each; two other stand-alone shower rooms and three separate toilets in ward one. There are the same numbers and combinations of showers and toilets in ward two, except there are no ensuites. The shower and toilet combinations in both wards have been adapted to make it easier for the young people in power chairs and bariatric equipment is available.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation and are dual purpose for either hospital or rest home residents throughout the facility. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids and wheelchairs. Mobility scooters and power chairs are placed along a back wall for charging purposes, although some residents especially the younger ones prefer them to be kept in their room. This request is honoured so long as there is not too much clutter and the health and safety of staff can be assured.</p> <p>A number of residents bedrooms have doors that open onto one of two decks (six rooms onto one deck and seven onto the other), or onto outdoor patio areas. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity,</p>	FA	<p>Communal areas are available for residents to engage in activities. Some of the younger people pursue their interests in their room or go out and said they do not use the communal areas as often, except for dinner. There is a large, combined dining and lounge area with the dining area having strip vinyl on the floor and the lounge area is carpeted. Activities are often provided in this lounge area.</p> <p>A smaller 'back lounge' that can open into the other lounge area provided another sitting and library area. Both lounge areas have a large television in them. The development of a small quiet sitting area is almost completed.</p> <p>The dining and lounge areas are spacious and enable easy access for residents and staff. Furniture is</p>

and dining needs.		<p>appropriate to the setting and residents' needs.</p> <p>Many visitors and residents choose to sit on one of two decks available.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is contracted out and undertaken off site. Laundry bags for the collection of dirty linen are covered. Cleaning staff are responsible for ensuring linen is ready for collection each morning. A delivery, checking and ironing process is then undertaken before personal items are returned to residents. Despite the four-day delay, there were no comments about this in the residents' survey results and none of the residents interviewed made any comment.</p> <p>There is a small, designated cleaning team. These staff have completed the New Zealand Qualifications Authority Certificate in Cleaning (Level two) and are now doing level three, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. The cleaning staff described how they ensure these remain safe on their lockable cleaning trolley when they are using them around the facility. A list of cleaning duties and a spring-cleaning schedule are available.</p> <p>Cleaning and laundry processes are monitored every six months through the internal audit programme. The last laundry audit was March 2021 with no corrective actions required. The internal audit laundry tool is about to be modified as many of the options on the tool are not applicable as laundry is done off site. The latest cleaning audit was April 2021, and one corrective action was raised. It is still too recent for resolution to have been completed and checked.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 24 November 2002. A trial evacuation takes place six-monthly and a copy sent to the New Zealand Fire Service, with the most recent being on 17 December 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures and informed they are updated on these annually via the 'GEM' training days. The most recent updates were February and again April 2020 due to additional staff turnover.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for a full contingency of residents and staff. Emergency lighting is regularly tested and this was confirmed in records sighted.</p> <p>A digital electronic system enables a minute staged alert system to occur from the staff on duty to the clinical manager, the business and care manager to the regional clinical manager at eight minutes. Internal audits of</p>

		<p>the functioning of the call bells are undertaken in the maintenance person's monthly checklist. Residents and family/whānau believed staff response times were satisfactory.</p> <p>Appropriate security arrangements are in place. Windows have security latches in situ and doors and windows are locked and curtains are pulled at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and most have doors that open onto outside garden or decked courtyard areas. Heating is provided by heat pumps in residents' rooms and in the communal areas with ceiling mounted heating in corridors. Areas were warm and well ventilated throughout the audit and residents and family/whānau confirmed the facilities are maintained at a comfortable temperature.</p> <p>Residents may smoke outdoors in a gazebo and staff go elsewhere. The site is expected to be Smokefree from October 2021.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Te Mana implements an infection prevention and control (IPC) programme to protect residents, staff and visitors from infection and to provide the highest standard of care in line with best practice. The programme is guided by a comprehensive and current infection control manual, with input from appropriate agencies and staff including clinical and quality managers, infection control nurses and other personnel within the facilities operated by Oceania Healthcare, as well as from general practitioners, pharmacists and microbiologists. The infection control programme and manual are reviewed annually (24 March 2021).</p> <p>An RN is the designated IPC coordinator, whose role and responsibilities are defined in a job description, with support and oversight from the CM. Infection control matters, including surveillance results, are reported monthly to the business care manager, the regional clinical and quality manager, nursing and clinical strategy at Oceania national support office. Matters are discussed at monthly IPC committee meetings, which is attended by CM, RN, and representatives from kitchen, housekeeping, maintenance and health care assistants.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> <p>During periods of Covid-19 restrictions guidelines were followed from the Oceania national support office (guided by the Ministry of Health) and passed on to staff in all departments in writing. QR codes and sign in books were available for contact tracing inside the main entrance.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control nurse has access to relevant and current information, appropriate to the size and complexity of this service. Infection control is an agenda item at the facility's staff meetings, evidenced during review of meeting minutes and interviews with staff. The internal audit programme includes infection control audits to monitor the implementation of the infection control programme. The IPC coordinator has completed online training in the last twelve months as verified in training records.</p> <p>Outbreak kits were available to support the programme and any outbreaks of infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control policies and procedures are relevant to the service and reflected current accepted good practice and relevant legislative requirements. Policies are accessible to all personnel, stored in the nurses' station in hard copy and online. The infection control policies and procedures are developed and reviewed regularly in consultation and input from relevant staff and external specialists (March 2021).</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support</p>	FA	<p>Infection control education is provided to all staff and forms part of staff orientation and education as part of the ongoing in-service education programme.</p> <p>Interviews with staff advised that clinical staff identify situations where infection control education is required for a resident, including hand hygiene and cough etiquette.</p> <p>The infection control staff education is provided by the CM. Additional education has been held covering</p>

staff, and consumers.		pandemic management and donning and doffing personal protective equipment as recommended for Covid-19.
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	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator and CM reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. A computer programme generates graphs that identify trends for the current year, and comparisons against previous years and this is reported to the IPC committee and the regional CM and national clinical strategy team. The facility's surveillance data is benchmarked against other Oceania facilities and this information is shared with staff and management. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, four residents were using restraints, with one person using two different types and three residents were using enablers. Enablers in use were the least restrictive in nature, constituted bed rails for one person and bed side levers for two others and all were being used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the registered nurse and staff and quality meeting minutes, files reviewed, and from interviews with staff. Those currently in use are bedrails, lap belt and a chair brief.</p>
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint	FA	Restraint management, including approval, is a component of weekly registered nurse meetings led by the restraint coordinator who is also the clinical manager and has been in the role for more than six years. The nurse practitioner is involved in any discussions relating to the approval of restraint or any changes relating to enabler and restraint use. Meetings minutes, records in residents' files documentation in a folder dedicated to restraint related records and verbal reports from registered nurses, the restraint coordinator and the nurse practitioner confirmed there are clear lines of accountability associated with these processes and the overall

<p>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.</p>		<p>use of restraints is being monitored and analysed.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The restraint coordinator described the process for the assessment of restraint use, which was consistent with policy documentation. An initial assessment and approval process is undertaken by a registered nurse and the restraint coordinator in consultation with the both the nurse practitioner and the resident's family/whānau/EPOA. The documented assessment process identifies the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. There is an option in the electronic support plan for a dedicated support plan in relation to restraint management and enabler use. This includes a goal plan, interventions, reviews, management strategies and assessed reasons for restraint. Completed assessments were sighted in the electronic records of residents who were using a restraint and in a folder with documentation pertinent to the use of restraints. These included all requirements of the Standard. The restraint coordinator noted the desired outcome is always to ensure the resident's safety and security. Evidence of family/whānau/EPOA involvement in the decision making was on file in each case.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family/whānau members including, for example, low beds and sensor mats. These discussions are noted on the assessment forms.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring are electronic and those viewed included the necessary details. Access to advocacy is provided if requested with family/whānau usually taking on this role. All processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained and updated every month and as changes occur. Restraint use is regularly reviewed weekly the hard copy restraint and enabler registers included details on who is currently using restraint or an enabler, what restraints are in use and sufficient information to provide an auditable record.</p> <p>Staff have received annual training on the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours and managing people who have a risk of falling. Those spoken with understood that the use of restraint is to be minimised and described restraint monitoring processes.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated by the restraint coordinator every two months, during care plan and interRAI reviews, six monthly restraint evaluations and at the registered nurse meetings. Family/whānau sign off the review process, which confirms their involvement in the evaluation process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, whether the policy and procedure was followed, and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Under the leadership of the clinical manager/restraint coordinator, all registered nurses, who operate as the restraint committee, review enabler and restraint use at their weekly meetings and the restraint coordinator formally reviews restraint use every two months. These actions are supplemented by six monthly reviews of all individual and organisational restraint use at staff and quality meetings, which are usually held two-monthly, and these cover all the requirements of this Standard. Restraint use is also recorded on the clinical indicators report provided to the regional clinical manager each month. Records reviewed confirmed evaluations of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and family/whānau.</p> <p>The regional clinical manager confirmed their involvement in reviewing restraint use in all facilities they oversee. The results of an internal audit that is carried out every six months also informs these meetings. The restraint coordinator confirmed that any changes to policies, guidelines, education and processes are implemented if indicated and they described efforts to minimise the use of restraints that included increasing restraint free periods as often as possible.</p> <p>Staff records confirmed that all staff have a current restraint competency, which they undertake at orientation and every two years thereafter. All staff had also undertaken restraint minimisation and safe practice training in 2020.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	CI	There were two external areas that have wings of the facility surrounding all four sides of each. These are referred to as internal courtyards. A project was developed to improve these areas as investigations found that between 2018 and 2020 only 6% of people were spending time outdoors and residents were otherwise confined to indoor areas. The outdoor space was underutilised due to uneven pavers, which were not safe for people with walking frames and provided no access for lazy boy chairs or power wheelchairs. A goal for 60% of residents to spend time outdoors by April 2020 was set. A ‘cause and effect’ diagram was developed as part of the project plan, a survey around what the courtyards were lacking was completed by residents and family/whānau and a process map was set out. On completion of the project, a review of the use of the courtyards in October 2019 showed 87% of people were using it and a further review in April 2020 confirmed the goal of 60% use had been surpassed. Positive comments were provided and the conclusive statements from the project managers and coordinators in a PowerPoint presentation were that ‘Having the courtyards accessible to residents and family/whānau has enhanced their feelings of wellbeing. The young people with disabilities noted how much easier it is to get outside than previously. The time family/whānau spend visiting the facility has become more frequent because of the relaxed, enjoyable and spacious environment where family/whānau continue to make memories. Future planning will include regular	A project to transform two external courtyards to more suitable environments to encourage residents to go outside on a more regular basis was undertaken and completed. Use of these areas has since escalated from 6% to more than 60% and reports state that the time family/whānau spend

		<p>family/whānau gatherings to allow family/whānau to come together in a non-institutional environment.’ One of the courtyards is covered by an ‘archgola’ and the other is open air, but large outside umbrellas are used. By the time of audit, photographs confirmed family/whānau gatherings have occurred and sometimes family/whānau will book the space for special events.</p>	<p>visiting the facility has become more frequent because of the relaxed, enjoyable and spacious environment where family/whānau continue to make memories.</p>
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End of the report.