

Oceania Care Company Limited - Eversley Rest Home and Village

Introduction

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

The audit has been conducted by 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:	Eversley Rest Home and Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 3 February 2022 End date: 4 February 2022
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:	48

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

Oceania Care Company Limited - Eversley Rest Home and Village (Eversley) provides rest home, hospital and secure dementia level care for up to 50 residents. The secure dementia unit contains 17 beds. All remaining beds, with the exception of one bedroom, are suitable for the provision of either rest home or hospital level care. The service is managed on a day to day basis by a business and care manager and a new clinical manager.

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 members, management, staff, the physiotherapist, a palliative care nurse, the nurse educator overseeing competency assessment programme (CAP) students and a general practitioner.

Residents and families spoke very positively about the care provided.

This audit has resulted in two areas identified as requiring improvement. These relate to corrective action and care planning.

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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Eversley Rest Home and Village ensures the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is readily available to residents. Opportunities to discuss the Code, consent and the availability of advocacy services is provided when the resident is admitted and thereafter as required.

Eversley provides services in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The one complaint received in the last year has been investigated and responded to in a timely manner.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The business plan, clinical excellence strategy and other documents detail the scope, goals, and values of the organisation. There are appropriate processes in place to monitor and report on key aspects of service through to senior managers/executive team. An experienced and suitably qualified person manages the facility and is supported by a clinical manager.

The quality and risk management system includes internal audits, satisfaction surveys, collection and analysis of quality improvement data including clinical indicators, benchmarking, and quality improvement projects.

Adverse events are being reported. 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.

The recruitment, appointment, orientation and management of staff is based on current good practice. There is a systematic approach to identify and deliver relevant ongoing training which supports safe service delivery and includes regular individual performance review.

Staffing levels and skill mix requirements are documented on policy. There is always at least one registered nurse on duty. Staff working in the secure dementia unit have an industry approved qualification in dementia care or are working towards this.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained using integrated electronic files.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Eversley work closely with the local Needs Assessment and Service Co-ordination (NASC) service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family/whānau to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

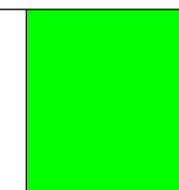
Care plans are individualised, based on a range of clinical information. All residents' files reviewed demonstrated that needs, goals, and outcomes are reviewed on a regular basis. Residents and family/whānau interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a good standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Registered nurses and care staff administer medications, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall 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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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment has been tested as required. Clinical equipment has evidence of current performance monitoring/clinical calibration.

Communal and individual spaces are appropriately ventilated and maintained at a comfortable temperature. Internal courtyard areas and external areas are accessible, safe and provide sufficient shade and seating. There is an internal courtyard and secure outside garden for residents living in the secure dementia unit.

Waste and chemicals/hazardous substances are stored securely. Staff use protective equipment appropriately. All laundry services are provided offsite. Cleaning is undertaken by employed staff daily.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. The New Zealand Fire Service have approved the fire evacuation plan. Fire drills are conducted at least six monthly. Call bells are appropriately located. Security cameras are in use and security systems are appropriate for the services provided.

Residents can smoke in a designated area. There is a no smoking or vaping policy on-site for staff.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Policies and procedures that support the minimisation of restraint are in place. There is one resident with restraints in use and one resident is using an enabler.

Staff are provided with training on restraints and enabler use during orientation and as a component of the ongoing education programme. Staff demonstrated a sound knowledge and understanding of the organisation's policies.

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 appropriately trained infection control nurse, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from the Hawke's Bay District Health Board. The programme is reviewed annually.

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, with data analysed, trended, benchmarked 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	48	0	0	2	0	0
Criteria	0	99	0	0	2	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>Eversley Rest Home and Village (Eversley) as part of the Oceania Care Company Limited, has policies and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in the yearly ongoing training programme provided. This was verified in training records.</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 consent.</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 showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information.</p>

		<p>Advance care planning, establishing, and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent, are defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Files reviewed of residents in the secure unit had either an activated EPOA or a Protection of Personal Property Rights (PPPR) order in place.</p> <p>Staff were observed to gain consent for day-to-day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility. Additional brochures about the Advocacy Service had been ordered and were being delivered to then be available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</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>When Covid-19 restrictions permit, residents are assisted to maximise their potential for self-help and to maintain links with their family/whānau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. During Covid-19 restrictions, visiting and outings are limited and occur within strict guidelines. Visiting is by appointment, and within limited hours. A declaration is required to be signed prior to entry. Evidence of vaccination, and the wearing of masks are required. For those visitors not vaccinated, entry restriction is as determined within specific criteria, as discussed with the Business Care Manager (BCM) at the time, and within Ministry of Health (MOH) guidelines. Residents' links with family/whānau and other community resources (see 1.3.7), is enabled within the clear guidelines outlined by the facility, in addition to phone</p>

		<p>calls, emails and regular newsletters.</p> <p>Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Feedback forms are also readily available.</p> <p>The complaints register is maintained detailing all complaints received. Complaints are entered into an electronic data base, which function includes identifying the timeframes for managing each step of the complaint. Complaints are reviewed by designated staff at support office who assess the risk rating. The business and care manager is usually responsible for complaints management, with the support of the clinical manager, and regional operations manager and the regional clinical manager as and when required. The business and care manager was able to detail the process that is undertaken should any oral or written complaints be received.</p> <p>There has been one complaint received since 1 January 2021. This was investigated and responded to in a timely manner, with appropriate support provided to the complainant. The staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from the Ministry of Health (MOH), District Health Board (DHB) or Health and Disability Commissioner (HDC) since the last audit. All residents and family members interviewed on this topic were aware of the complaints process. One family member stated they have arranged for their family member to have a private caregiver for two hours a day as they did not feel facility staffing levels were sufficient (refer to 1.3.3. and 1.2.8).</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents (eight) and family/whānau (seven) interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is</p>

		displayed in common areas around the facility, in English and Māori. A poster on the advocacy service is posted in the front entrance foyer, together with information on how to make a complaint and feedback forms. Additional brochures on the advocacy service have been ordered and the facility is waiting their delivery.
<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>Residents and family/whānau confirmed that the services they receive are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families and the GP. All residents have a private room. CCTV surveillance cameras are in operation in common areas throughout the facility. Notification of this fact is on display at the front entrance.</p> <p>When Covid-19 restrictions permit, residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each resident's care plan includes documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the facility's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training records.</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</p>	FA	<p>There were two residents and four staff members at Eversley at the time of audit who identify as Māori. Interviews verified staff can support residents who identify as Māori to integrate their cultural values and</p>

individual and cultural, values and beliefs.		beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers.
<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	Eight residents interviewed, verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and the results verified individual needs are being met.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family/whānau when interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	The service encourages and promotes good practice using evidence-based best practice policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care specialist, community dieticians, services for older people,

		<p>psycho-geriatrician and mental health services for older persons, and education of staff. Eversley provides residents access to an onsite physiotherapist every Friday. The physiotherapist assesses all new resident's mobility status, provides manual handling training to staff, and guides staff on how to best meet the residents' mobility needs.</p> <p>The organisation is committed to ensuring staff are trained to meet the needs of the residents. There is an ongoing yearly training programme in place, in addition to four onsite assessors being available to enable care staff to achieve qualifications in care of the older adult. All but two of 14 staff working in the secure unit have a recognised qualification in caring for a resident with dementia. Staff reported they receive management support for external education and access their own professional networks, such as on-line forums, to support contemporary good practice.</p> <p>The facility is committed to keeping residents involved in the community (refer 1.3.7).</p> <p>The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. An interview with the visiting palliative care nurse and the physiotherapist, verified satisfaction with the care provided by Eversley.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family/whānau stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family/whānau input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the Hawke's Bay District Health Board (HBDHB) when required. Staff knew how to access this service.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Eversley business plan (2022-2023) details the background, competitive analysis, key relationships and marketing, and goals/objectives of the organisation. This was developed by the BCM with support of the ROM, using a template framework provided by Oceania.</p> <p>There is a new chief executive officer (CEO) who was internally promoted and commenced in the new role on 22 March 2021. There are over 40 Oceania Healthcare retirement complexes in the group, some which have aged related residential care services located.</p> <p>Aged related residential care (ARRC) services have been provided at Eversley for many years by Oceania and previously other entities, initially at rest home level of care. Secure dementia level care was commenced in 1980, and hospital level care added in 2019. There are 17 bedrooms in the secure dementia unit. There are 33 bedrooms in the rest home and hospital, all except one is suitable for the provision of rest home or hospital level care (dual purpose). Preparation work is well underway for Oceania to build 56 new care suites on site that will join with the existing care home. The building project is expected to commence in April 2022.</p> <p>There is an Oceania clinical excellence strategy. This has been developed by the general manager of clinical and care services and details the vision, three core principles (clinical excellence, resident centred care, and employer of choice) and three strategic priorities (risk management, resident wellbeing and clinical capability).</p> <p>The Eversley business and care manager (BCM) is a registered nurse (RN), who maintains a current annual practising certificate (APC), and has been the business and care manager at Eversley for eight years. The business and care manager has worked in the aged related residential care (ARRC) sector since 1998 and held senior management roles in a number of other facilities and organisations. The BCM is responsible for financial, staffing, health and safety issues and building/facility management and reports to, the longstanding regional operations manager, and regional clinical manager, who has been in the role approximately 18 months. The regional operations manager (ROM) and regional clinical manager (RCM) expressed satisfaction that appropriate issues are being communicated in a timely</p>
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		<p>manner.</p> <p>The business and care manager is supported by a clinical manager (CM), who commenced in this role on 16 September 2021. The CM is new to Oceania Healthcare, however, has worked in other aged related residential care (ARRC) facilities both as a registered nurse (RN) and as a clinical manager. The clinical manager is responsible for ensuring the clinical needs of the residents are being met. The CM has a post graduate diploma in health science and stated is undertaking further education on a nurse practitioner qualification pathway.</p> <p>The business and care manager has exceeded eight hours of education per annum related to managing an aged related residential care facility as required by the providers contract with Hawke's Bay District Health Board (HBDHB).</p> <p>The facility has an Aged Related Residential Care Contract (ARRC) with Hawke's Bay District Health Board (HBDHB) for the provision of rest home, continuing hospital level care and secure dementia care. There were 48 residents receiving care at the time of audit. This included 18 residents at long term rest home level of care, 13 residents at ARRC continuing (hospital) level of care, and 16 at secure dementia level of care. There is a mental health in ARCC Contract. There is one resident receiving rest home level of care under this contract. Other contract's includes categories for respite and day care services and 'restore' in ARCC. There were no residents receiving care under these contracts 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>	<p>FA</p>	<p>In the business and care manager's absence, the CM is responsible for the oversight of care and services provided. The clinical manager was able to detail the responsibilities in the BCMs absence both planned and unplanned and confirmed appropriate supports are available. The regional quality manager and the regional operations manager confirmed they are available for advice and support. In addition, the management teams and the other Oceania ARRC facilities located nearby can also be contacted for advice and support as and when required.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>Eversley has a quality and risk management system which is understood and implemented by service providers. This includes internal audits/reviews, satisfaction surveys, incident and accident reporting, health and safety/hazard management, infection control data collection and management, and concerns/complaints management. There is an internal audit schedule. Templates are used for each audit. The results of at eleven sampled audits demonstrated that there was a high level of compliance with the organisation's policies. The results are communicated to applicable staff.</p> <p>The health and safety committee meets monthly and is attended by the administrator who is the health and safety representative, the maintenance person, two health care assistants (HCAs), including one working at night, the diversional therapist (DT) and two registered nurses. Meeting minutes demonstrated discussions on staff injuries/accidents, regular review of the hazard register, monitoring H&S key performance indicators, ensuring staff have completed applicable H&S training including at orientation, and that applicable internal H&S audits have been completed and the results communicated. The H&S representative reports there is active communication of any new hazards and these are reviewed and actions taken.</p> <p>The results of the 2021 resident satisfaction survey undertaken in August 2021 was sighted. There were 14 respondents. The majority of respondents agreed or strongly agreed they were satisfied with the aspects of care and environment that were included. In addition, the family of all new residents are contacted by a staff member from support office six weeks after the resident's admission seeking feedback on services and how the resident is settling in.</p> <p>Appropriate quality information is shared with staff via shift handover as well as via the regular staff meetings. There are resident meetings, monthly health and safety meetings, monthly registered nurse meetings, two monthly restraint minimisation meetings, and one to two monthly staff meetings. There is a quality improvement meeting which is the forum where all applicable issues are discussed. The minutes of three meetings verified discussion occurs on health and safety, Covid-</p>

		<p>19, internal audits, education/training, resident feedback, clinical issues, incidents/accidents, changes to suppliers/consumables, use of restraint/enablers, infection data, and human resources. Staff interviewed verified they were informed of relevant quality and risk information. Opportunities for improvement are discussed, along with the organisation's expectations, policies/procedures and any changes in process or practice.</p> <p>Policies and procedures are available to guide staff practice and are developed nationally. These are available for staff electronically on the intranet. A paper copy of clinical policies is available on site for staff in the nurses' station. The clinical manager is the document controller and prints the updated document and provides this for staff to read and sign.</p> <p>There are a range of clinical indicators that are monitored monthly including falls, choking, absconding, infection, pressure injuries, and medication errors/events with data reported from the other Oceania ARRC facilities. There is a high rate of falls at Eversley. While interventions are being undertaken in response to individual falls, a clear overall action plan reviewing and addressing possible contributing factors has not yet been developed. This is an area requiring improvement, and links with 1.3.5.2.</p> <p>Actual and potential hazards/risks are identified in the hazard, risk and hazardous substances registers sighted. The business and care manager and the regional operations manager described the organisation's risks and ongoing mitigation strategies. The ROM interviewed confirmed being satisfied that new or changing risks are being communicated in a timely manner and appropriate mitigation strategies are implemented. Resident specific risks are evaluated during interRAI assessment and care plan reviews.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open</p>	<p>FA</p>	<p>Policy and procedure details the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme.</p>

<p>manner.</p>		<p>Applicable events have been reported in a timely manner electronically. Sampled events have been disclosed with the resident and/or designated next of kin. This was verified by residents and family members interviewed, and records of communications maintained in the sampled residents' files. A review of reported events including witnessed and unwitnessed falls with and without injury, a pressure injury, a bruise, behaviour, a medication event, absconding, and a staff injury related events demonstrated that incident reports are completed, investigated and responded to in a timely manner. However, care plans are not consistently updated when required or short-term care plans developed, and a clear organisation corrective action plan has not been documented in response to falls although some interventions have been undertaken. These issues are included in the areas for improvement raised 1.2.3.8 and 1.3.5.2.</p> <p>Incidents/events have also been discussed with staff at the various staff meetings as verified by interview and observation of meeting minutes. A range of incidents/adverse event data is also included in the internal clinical indicator/benchmarking programme (refer to 1.2.3). A health and safety board is located outside the staff room. This contains a quick reference poster on the incident reporting system and copies of reporting forms.</p> <p>The BCM advised there have been essential notifications to the Ministry of Health and/or District Health Board since the last audit related to the changes in clinical manager, infection outbreak, residents with pressure injuries, registered nurses' shortage, and one resident that absconded. The BCM can detail the other type of events that require reporting and stated any notifications are undertaken by the national quality, compliance and audit manager. One additional event was noted where a resident in the rest home and hospital wing absconded and the police was subsequently notified. The resident was located and returned by a family member. The BCM advised this event was inadvertently not notified. This is not raised as an area for improvement as is not a systemic issue.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>Human resources management policies and processes are based on</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>good employment practice and relevant legislation.</p> <p>The recruitment process included completing an application form, interview, referee checks, and verification of qualification where applicable. The successful candidate is required to have police vetting, provide the results of a drug screening test, complete a health questionnaire and allow a summary of any current or historical claims with the Accident Compensation Corporation (ACC) be obtained. The job description/employment contract was present in sampled files along with a privacy/confidentiality agreement. A sample of eight staff records reviewed confirmed that policies are being implemented and records retained.</p> <p>All employed and contracted registered health professionals (RHPs) have a current annual practising certificate (APC). Copies of the APCs are on file.</p> <p>Staff induction/orientation includes all necessary components relevant to the role. Staff reported that the induction/orientation process suitably prepared new staff for their role and responsibilities. Additional time is provided if this is identified as required. Staff records reviewed showed documentation of completed orientation and the associated competency assessment applicable for the role is completed within required timeframes or is in progress.</p> <p>A comprehensive staff education programme is in place with in-service education identified and opportunities/toolbox sessions (including those noted in the H&S plan) provided most months. Topics have included Covid-19, chemical safety, falls management, moving and handling, first aid, hearing aid care, wound care, bullying in the workplace, use of the 'stop and watch' tool, fire safety and other topics. Staff must attend a mandatory study day annually relevant to their role each year that is facilitated nationally, and undertake annual competencies. The study day for health care assistants has been changed to include discussion on how the topics discussed impact on the care of a resident, that has a made-up history and profile. Records of attendance/competency are maintained and monitored. While not all education has been provided in 2021 due to national Covid-19 precautions, regular training has occurred.</p> <p>Care staff are encouraged to complete a New Zealand Qualification</p>
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		<p>Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. There are four staff employed that are approved assessors including the CHM, the CSM, and a registered nurse in both the secure dementia unit and the rest home / hospital area. Fourteen HCAs have an industry approved qualification in dementia care. There is one staff member new to the service that has been enrolled for this training. Other staff have the opportunity of completing a level two, level three or level four NZQA qualification.</p> <p>The CHM meets with new staff for a 'catchup' within three months of employment. Annual performance appraisals are subsequently undertaken with all staff. These were completed in applicable staff files reviewed. There are systems in place to identify when these are next due.</p> <p>Twenty-three staff have completed first aid training. The five staff that were due refresher training at the end of 2021 were unable to attend training due to Covid-19 restrictions. These staff have been booked to complete this training in March 2022. There is at least one staff member on duty at all times with a current first aid certificate. Those staff responsible for medicine administration have current medicines competency and records are retained of this. Twenty-four staff have current medicine competency.</p> <p>Students completing a nursing competency assessment programme (CAP) are at Eversley. This is one component of the strategy to increase the pipeline of RN's both within the ARRC sector and for Oceania. The RN educator responsible for oversight of the CAP students was interviewed, and spoke positively about the support offered to students by staff at Eversley.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7).</p> <p>Care staff reported there were generally sufficient staff available to complete the work allocated to them, and that there is a system in place to arrange replacement staff in the event of an unplanned absence. Observations and review of a four-week roster confirmed</p>

	<p>there is always a minimum of three healthcare assistants and one registered nurse on duty, with more rostered on during the morning and afternoon shifts. This is in addition to the clinical manager (who works weekdays), and BCM who works Monday to Thursday. Both the BCM and the CM are RNs with a current APC. There is also a RN working in the secure dementia unit for a morning shift four days a week.</p> <p>The GP visits routinely two times each week (Monday and Thursday). The physiotherapist visits for a half day each week. The podiatrist visits six weekly, and dietitian comes at request.</p> <p>There are sufficient allocated hours for cleaners, maintenance, activities, catering staff and administration as verified by staff interviewed and review of the rosters. All laundry services are provided offsite at another Oceania care home.</p> <p>The roster is developed by a staff member off-site and provided to the BCM for review. There is a rolling roster with most HCAs working a four on and two off pattern. There is a set roster for the RN's and other staff. Staff are rostered to work in a designated area of the facility and allocated to work with designated residents. The roster is issued at least one month in advance. Processes are in place to cover unplanned staff absences. The required and actual RN and caregivers' hours are monitored by the business and care manager monthly and have been recently adjusted in response to identified residents' needs. While the staffing numbers rostered exceeded the hours required by the staffing framework, there is a high resident falls rate. A more comprehensive review of the falls data with consideration of staffing patterns has not been sufficiently detailed. This is included in the area for improvement raised in criterion 1.2.4.2. A family member expressed concerns about insufficient staffing for two hours in the afternoon in the rest home / hospital and have employed a private caregiver to be with their family member during this time (refer to 1.3.3). Other residents and family members interviewed were satisfied their care needs were being met in a timely manner.</p> <p>The clinical manager and six registered nurses have current interRAI competency. On the days when there are two RNs rostered on duty in the rest home/hospital, one of the RNs is allocated time for the GP round, infection prevention and control, interRAI and other designated</p>
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		<p>activities if required.</p> <p>The BCM advised there is one RN and two casual HCA vacancies, at the time of audit.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Residents' records at Eversley are now transitioning to an electronic system. For some older records the resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. The new electronic system continues to use the resident's NHI number as the unique identifier. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records of present residents are held securely on site. Residents who no longer reside at Eversley have their records stored offsite. All records are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents can be admitted to Eversley when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prior to entry the clinical manager (CM) and BCM undertake a risk assessment of the resident. Any areas identified as posing a risk, require approval of consideration for admission by the regional clinical manager (RCM) who assesses whether the facility can manage the risk identified. Once approval for admission has been approved, the prospective residents and/or their family/whānau are encouraged to visit the facility prior to admission and meet with the BCM and the CM. They are also provided with written information about the service and the admission process.</p>

		<p>Residents requiring admission to the secure unit, require a specialist's authorisation for placement and an activated enduring power of attorney (EPOA) or protection of personal and property rights (PPPR) order in place.</p> <p>Family/whānau members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the HBDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff member 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.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current</p>

		<p>use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. 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 recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>There was one resident who self-administers vitamins at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Eversley.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service at Eversley is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in October 2021. Recommendations made at that time have been implemented.</p> <p>An up-to-date food control plan is in place. A verification audit of the plan was undertaken 20 June 2020. The next verification audit is due 20 June 2022. The plan was verified for two years as part of the Ministry of Primary Industries (MPI) approved multi-site verification guidelines. Paperwork is in place to verify the supplying of food scraps to feed a local farmers pigs meets the required guidelines to verify the</p>

		<p>scraps are treated properly.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and in resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p> <p>Residents in the secure unit have access to food and beverages at any time day or night.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission to Eversley, residents are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, behaviours, nutritional screening, and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation, and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents had current interRAI assessments completed. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Care plans reviewed reflected a range of residents' support needs, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities note, medical and allied health professional's notations. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>There were three of nine care plans that did not describe fully the required support the residents required to meet the desired outcomes. This is an area requiring attention and links with 1.2.3.8.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Except for that referred to in criterion 1.3.5.2, documentation, observations, and interviews verified the care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A diversional therapist and an activities assistant provide the activities programme. The roster included a five-day allocation of the activities staff member allocated to the secure unit. There is a twenty-four-hour activities/lifestyle plan for residents in the unit. The plan addresses residents twenty-four hour needs and previous lifestyle patterns. Activities are held in the secure unit and the hospital/rest home area.</p> <p>A social assessment and history are 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 regularly and as part of the formal care plan review every six months.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included sit exercises, news, balloon games, mocktails and chocolate, church services, quizzes, games, visiting entertainers and several community generated activities. Residents have a knitting group that makes angel pockets for new-born babies. The residents of Eversley support the 'Hawkes Bay Pyjamas in June' event by raising money to provide warm pyjamas for underprivileged children during the winter. Last year Eversley provided 50 pairs of pyjamas. Residents support suicide prevention initiatives by raising</p>

		<p>funds through raffles and wear a wig day. The activities programme is discussed at the bimonthly residents' meetings. Minutes indicated residents' input is sought and responded to.</p> <p>Residents have requested that they would like to know if residents move somewhere else or die. This information had previously not been shared with residents. There is now a memorial service if a resident dies, and residents are enabled to share their memories of that person. There is also a memorial service at the end of each year remembering residents who have died during the year. Resident and family satisfaction surveys demonstrated satisfaction with the activities programme at Eversley. Residents interviewed confirmed they find the programme meets their needs. On the day of audit, discussion was held around remembering February 4, the day of the Napier earthquake in 1941.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. The RN documents evaluations. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short-term care plans being reviewed for infections, pain, and weight loss. Progress was evaluated as clinically indicated. Wound care plans were evaluated each time the dressing was changed. Behavioural management plans were reviewed after each behavioural event. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP/RN/CM sends a referral to seek specialist input.</p>

<p>to meet consumer choice/needs.</p>		<p>Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN/CM or the GP. The resident and the family 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.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Cleaning, maintenance, and kitchen staff have completed training in the safe handling of chemicals with the product supplier. The chemical supplier also reviews how the products are being used in the cleaning and food services on a regular basis and provides a report. The safe handling and use of chemicals is also included in the orientation and ongoing education programme for all care staff and registered nurses. The housekeeper in the secure dementia unit advised always keeping all cleaning products within their direct vision and arms reach.</p> <p>Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of appropriate protective clothing and equipment, and staff and visitors were observed using these items appropriately.</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 (expiry 17 January 2023) was publicly displayed.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment (due March 2022), calibration of bio medical equipment (completed in November 2021 and January 2022), was current as confirmed in documentation reviewed, interviews with the maintenance manager, as well as observation of the</p>

		<p>environment. Every call bell is checked monthly as part of an audit. The environment was hazard free, residents were safe, and independence was promoted.</p> <p>All residents' bedrooms are single occupancy. One bedroom in the rest home/hospital area is suitable for the provision of rest home level of care only. All the other beds are suitable for both rest home and hospital level of care (ie, dual purpose).</p> <p>External areas were safely maintained and appropriate to the resident groups and setting. The rest home and hospital area is built around two internal courtyards. There is another internal courtyard in the secure dementia area along with an outside garden and walking path that residents can use. There is secure fence around this area. Climbing plants have been used to cover most of the fence, reducing its visual prominence, and creating a more ambient area for residents. Some maintenance has recently occurred on the pathway. There is appropriate outside furniture and shade available.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they were happy with the environment. There is a maintenance request book in the administrator's office. This demonstrated that maintenance requests were completed in a timely manner.</p> <p>Eversley has access to a vehicle from another nearby Oceania facility for resident activities.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are sufficient toilet and shower rooms in the secure dementia unit. This comprises a combination of separate toilet and shower rooms, and a shower/toilet in the same room. There are signs used to note when these rooms are occupied.</p> <p>In the rest home / hospital area, all except three resident bedrooms have an ensuite toilet and handbasin. There are adequate numbers of accessible bathroom and toilet facilities throughout the care home. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories according to</p>

		individual requirements, are available to promote residents' independence. This includes the use of commodes and shower chairs when deemed clinically appropriate. There is also a staff toilet and a visitor toilet.
<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 personal space is provided to allow residents and staff to move around within their bedrooms safely. Furniture is provided in each suite; however, residents can use their own if they want. Rooms were personalised with furnishings, photos and other personal items displayed.</p> <p>There are areas for the storage of other equipment including mobility aids, wheelchairs and clinical consumables. Staff and residents reported the rooms are spacious, with space for personal possessions and mobility equipment.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are separate lounge and dining areas in the rest home/hospital, and a co-located lounge and dining area in the secure dementia unit. All meals are prepared in the kitchen. There is a café area, a hairdressing salon, and small areas with rest/relaxation chairs along some of the corridors.</p> <p>All dining and lounge areas are spacious and enable easy access for residents and staff. Furniture is appropriate to the setting and residents' needs. Communal areas are also used for the activities programme and for residents' individual activities. Residents and family members interviewed confirmed the facility is comfortable.</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 services are undertaken offsite at another Oceania ARRC facility. This includes laundering residents' personal clothing, all facility linen and housekeeping supplies. There is a daily delivery of clean linen and collection of laundry for reprocessing. Residents' clothing is normally returned within 24 hours. Clean facility linen is unpacked by the housekeeping staff. The resident clothing is sorted and ironed if</p>

		<p>required by the HCAs, before being distributed.</p> <p>There are designated housekeeping staff on duty each day including weekends. The housekeeping staff have received appropriate training including chemical safety use provided by the chemical supplier. Chemicals were stored securely and were in appropriately labelled containers. A chemical auto-dispenser is utilised. A cleaning schedule details the tasks to be completed, frequency and product to be used. Cleaning and laundry processes are monitored through, the internal audit programme with a high level of compliance noted, residents' meetings, and the resident satisfaction survey.</p> <p>Residents and most family interviewed reported their laundry is managed well and their clothes are returned in an acceptable timeframe, and the facility is kept clean and tidy. One family member noted taking the resident's clothing home for laundering, as some garments had gone missing for periods of time soon after admission, and this process was thought to be easier.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are available 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. Two flip charts are present as a quick reference in strategic locations including the nursing station. These included the emergency response for a range of loss of utility emergencies, clinical emergencies and hazardous substance events. There is an Eversley business and continuity plan that has additional detail included.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on 12 February 2007 (3/16/1/2/003). A trial evacuation takes place six-monthly with the most recent being on 29 September 2021. The new staff orientation programme includes fire, emergency and security training. Staff confirmed their awareness of the emergency procedures. There is a register on site that is checked and updated daily identifying the level of assistance required by residents in the event of an emergency. A copy of this list and resident next of kin data is included in the 'grab and go' bag.</p>

		<p>Adequate supplies for use in the event of a civil defence emergency, including food for up to three days, at least 1000 litres of water (including a roof holding tank), blankets/duvets, batteries, continence supplies, disposable cutlery and plates, lighting, a first aid kit, and gas cooking, were sighted to meet the requirements for the up to 50 residents. There is an uninterrupted battery supply (UPS) for emergency lighting. The civil defence supplies are stored appropriately and checked against a contents list six monthly. There are additional PPE supplies for use in an outbreak. There is at least one staff member on duty at all times with a current first aid certificate.</p> <p>Call bells alert staff to residents requiring assistance. These alert audibly, display a light outside the room, and display the locations to ceiling mounted panels. Call bells are present at the bed space and bathrooms.</p> <p>Appropriate security arrangements are in place. Surveillance cameras are installed monitoring internal communal areas, the entrance and some external areas. Images are displayed in the clinical manager office, and stored files are accessible by other authorised personal only. Signage alerting residents and visitors to the use of cameras was installed during audit. The BCM states having accessed the archived images as part of an incident review process. Doors and windows are locked at a predetermined time and care staff note they check the security of all doors and windows when they close the curtains in each resident's room at night. The RN double checks later in the shift and again at handover, and sign the checks as completed on the RN handover form.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms have windows of normal proportion. These include opening into the internal courtyards or outside of the building. There are small windows that can be kept open if residents request. The windows sighted have security stays insitu.</p> <p>A combinator of radiator panel heating, ceiling ducts and heat pumps are used for heating. Residents and family interviewed were satisfied the care home is kept appropriately warm and ventilated. The temperature of the heating is adjusted by staff as required. There are</p>

		<p>windows that open and ceiling fans in some communal areas for ventilation / cooling when required.</p> <p>There is a designated area for residents to smoke on site. There is no smoking or vaping onsite for staff.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Eversley provides a managed environment that minimises the risk of infection to residents, staff, and visitors through the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level. The infection control programme and manual are reviewed annually.</p> <p>The RN with input from the CM is the designated infection control nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CM, and tabled at the quality/risk/meeting, RN, and staff meeting. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisation's RCM is informed of any IPC concern.</p> <p>Covid-19 restrictions at the time of audit, require visitors to make an appointment to visit, prior to visiting. The visitor is required to be vaccinated and wear a mask. They are required to sign a disclosure statement disclosing risks of potential Covid-19 exposure. There is an organisation wide Covid-19 pandemic plan, that details the actions to be taken during each traffic light level.</p> <p>Signage at the main entrance to the facility also 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 related responsibilities.</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</p>	FA	<p>The infection control nurse (ICN) has appropriate skills, knowledge, and qualifications for the role. The ICN has undertaken post graduate training in infection prevention and control and attended relevant study</p>

<p>needs of the organisation.</p>		<p>days, as verified in training records sighted. Well-established local networks with the infection control team at the HBDHB and assistance from the organisation's infection control advisors are available if required. The nurse has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICN confirmed the availability of resources to support the programme and any outbreak of an 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>	<p>FA</p>	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICN. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent respiratory outbreak when the facility went into lockdown in August 2021, during a scabies outbreak in August 2020, and when there was a Norovirus outbreak in 2020.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their</p>

		room if they are unwell and increasing fluids during hot weather.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of infections at Eversley is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICN and CM review all reported infections. 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 quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>A good supply of personal protective equipment was available. Eversley has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	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 CM is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. The CM demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities involved.</p> <p>On the day of the audit, one resident (hospital level of care) was using a restraint. Bedside rails were the form of restraint in use. One other resident was using an enabler (bedrail). Enablers are the least restrictive and are only used voluntarily at a resident's request, and a</p>

		<p>written consent form is present in the resident's file.</p> <p>Restraint is being used at the request of a family member as part of a fall's prevention strategy. This was evident on review of records reviewed, and from interviews with staff, a family member and clinical manager interviewed. The use of restraint is included in the clinical indicator data monitored and reported on monthly.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval process involves the general practitioner, the CM who is the restraint coordinator, and a family/resident representative/EPOA, who are responsible for the approval of the use of restraints.</p> <p>A review of the applicable resident records and interviews with a registered nurse, the CM, and other care staff confirmed that there were clear lines of accountability and that the restraint currently in use has been approved. The overall use of restraints is being monitored and reported monthly at the quality meeting and at the two monthly restraint minimisation meetings.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on record in the applicable resident's records sampled and confirmed during interview with a family member (refer to 1.3.3).</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The CM/restraint coordinator undertakes the initial assessment with the input from the resident's family/whānau/EPOA. The individual resident's general practitioner is involved in the final decision on the safety of the use of the restraint.</p> <p>Completed assessments were sighted in the applicable resident's sampled record. A family member confirmed the bedrail restraint was used at their request, along with having a caregiver providing one on one care/observation of the resident for two hours each afternoon as part of a fall's prevention strategy.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraint is minimised as much as possible, and the CM/restraint coordinator and care staff discussed how alternatives to restraints are discussed and implemented with staff and family members, including the use of sensor mats and/or low beds. When restraints are in use, frequent monitoring (at least hourly) occurs to ensure the resident remains safe. There was evidence of regular monitoring. Any adverse events/incidents are required to be reported and followed up via the incident reporting system and included in the interRAI re-assessments and care planning process.</p> <p>Access to advocacy is provided if requested and all processes to ensure dignity and privacy are maintained and respected. A restraint register is maintained by the CM/restraint coordinator, updated as required, and reviewed/discussed at the two monthly restraint minimisation meeting, and quality meetings. The register was reviewed and detailed the resident currently using a restraint.</p> <p>Staff received training in the organisation`s policy and procedures and restraint minimisation practices during orientation and as a component of the ongoing education programme. Almost all applicable staff are noted to have completed the annual training requirements in 2021 as verified in the training records sighted. The management team obtain reports detailing when staff are due to for their annual restraint education / competency review.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of a resident`s records showed that the individual use of restraints was reviewed and evaluated during the care plan and interRAI reviews, the restraint minimisation committee meetings and at the quality meetings. This was verified by care staff and the CM/restraint coordinator interviewed.</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>The CHM/restraint coordinator undertakes a regular review of the resident with restraint use, most recently in January 2022, and a regular restraint audit (last completed 9 December 2021). These processes included the restraint used and type, whether all alternatives to restraint have been considered, the effectiveness of the restraint</p>

		<p>use, and the competency of staff, the appropriateness of restraint/enabler education and any feedback from the doctor, staff and families. The restraint committee meets two monthly. The membership includes the CM, an RN, a housekeeper, and at least one HCA. At times a chef, and the BCM attend to ensure all aspects of restraint minimisation are considered.</p> <p>Any changes to policies, guidelines, staff education/training and processes are implemented if indicated. Data reviewed, minutes and interview with the CM/restraint coordinator confirmed that minimisation of the use of restraint is a priority/focus.</p> <p>There is a national restraint minimisation meeting which occurred during the Oceania national clinical governance committee meeting on 13 May 2021. This committee monitors the use of restraint across all Oceania facilities per quarter and the stated intention is working towards having 'zero restraint'. The use of restraint at Oceania facilities is trending downwards.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA</p> <p>Moderate</p>	<p>Corrective action plans have been developed in response to internal audit findings, the complaint and some of the incidents sighted. Short term care plans or amendments to long term care plans are not consistently occurring when applicable following incidents/accidents including related to a fall or absconding. This is included in the area for improvement raised in criterion 1.3.5.2.</p> <p>There is a high falls rate with between 19 and 41 resident falls occurring each month, in the period sampled August 2021 to January 2022. There is evidence of the GP reviewing applicable residents' medications, treatment of infections, and interventions including the use of low low mattresses, and sensor alarms. However, while some monitoring is reported to have occurred of the time of</p>	<p>There is a high number of resident falls. While some corrective actions are undertaken in response to individual events, there is no evidence of a comprehensive review of all possible contributing factors and corrective action planning to minimise ongoing falls events.</p>	<p>Undertake more detailed analysis of all residents' falls and potential contributing risk factors, including staffing, the time of the fall, the location of the fall, and what the resident was attempting at the time of the fall. Incorporate the outcomes from this analysis into a clearly documented falls prevention corrective action plan, that is implemented and monitored for effectiveness.</p> <p>90 days</p>

		<p>the day a resident falls, this is not clearly documented in a manner that enables monitoring and comparison over time. In addition, the location of resident falls, and the activity the resident was engaging in at the time is not included in the analysis sighted. There has been a recent increase in the HCA staffing, however analysis with linkages to falls data was not sufficiently detailed.</p>		
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Care plans in six of nine residents' files described fully the care required to meet the residents' needs; however, three of the nine care plans did not address several complex events and the required plan to manage those events.</p> <p>A resident who had a fall and was uncooperative regarding neurological observations, had no short-term care plan in place that identified this as a problem. There was no documentation that family had requested neurological observations not be undertaken, or to detail any additional strategies to be implemented to ensure ongoing assessment of the neurological status that could be monitored. There was also no evidence of ongoing RN assessment post fall.</p> <p>A resident who frequently wanders away from the facility, has a global positioning system (GPS) tracking device in use. The resident's care plan does not sufficiently detail all the risks associated with the resident's wandering and</p>	<p>Three of nine care plans did not describe the interventions required to meet the residents' desired outcomes.</p>	<p>Provide evidence that care plans describe fully the interventions required to address each resident's needs.</p> <p>90 days</p>

		<p>associated behaviour. Neither is their evidence that all associated risks and the management of these have been fully discussed with and approved by the family.</p> <p>A resident who is a frequent faller, has no plan in place that acknowledges the number of falls, reviews of the falls to identify possible causes and subsequent update in interventions or actions to be taken to attempt to reduce the falls events (refer to criterion 1.2.3.8).</p>		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.