

Oceania Care Company Limited - Elmswood Rest Home

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Oceania Care Company Limited

Premises audited: Elmswood Rest Home

Services audited: Dementia care

Dates of audit: Start date: 23 February 2022 End date: 24 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: 37

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

Elmswood Rest Home is an Oceania Healthcare Limited facility that can provide care for up to 38 residents requiring dementia level of care, although one of the 38 bedrooms has always been used for storage. The facility was therefore full with 37 residents on site during this audit.

This certification audit was conducted against the relevant Health and Disability Services Standards and the service 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 family members, management, staff, and a nurse practitioner.

The most significant changes with the service since the last audit in October 2020, is the appointment of a new clinical manager and turnover of registered nurses (RNs).

Two areas were identified as requiring improvement at this audit. These relate to overdue interRAI assessments, and the timing and frequency of neurological observations and recordings for residents who have had an unwitnessed fall, or a fall that involved the head.

A continuous improvement rating was identified for the effectiveness and extent of quality improvement initiatives implemented in the home.

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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The service provides care that reflects the Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code is promoted and shared with residents' family/whānau and staff. Family/whānau and enduring power of attorney's (EPOAs) advised that residents are treated with dignity and respect.

Residents are encouraged to maintain cultural customs and connections with their community.

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

Communication needs are met.

There is a documented complaints management policy which is effectively implemented by the business and care manager who is responsible for managing complaints. Complaints are investigated in a timely manner with corrective actions implemented where required.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Oceania Healthcare Limited has a mission, vision and values that are conveyed to all concerned. An annual business plan specific to Elmswood Rest Home is developed and monitored for progress each year. All Oceania sites are linked by shared information management systems which enable quick access to facility information and monitoring of service delivery.

Services are managed by a qualified and experienced business and care manager, who is supported by a clinical manager responsible for the oversight and provision of clinical care. The clinical manager is a registered nurse and holds a current practising certificate. The regional clinical manager and the regional operations manager support the facility management team.

There is an Oceania Healthcare Limited quality and risk management system. Quality and risk performance is monitored through the organisation's reporting systems. Corrective action plans arising from quality activity results are documented and implemented. There is a database to document risks and controls.

A system is in place to report, analyse, and respond to adverse, unplanned, or untoward events. Adverse event information is openly shared with the residents' family members.

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

There is a documented rationale based on best practice for determining staffing levels and skill mix to provide safe service delivery. Staffing levels are adequate across the service and meet the requirements of the district health board contract.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Elmswood Rest Home is efficiently managed with relevant information provided to the potential residents' family/whanau or EPOAs. The registered nurses and the nurse practitioner (NP) assess residents on admission. The care plans demonstrated appropriate interventions and were individualised. Residents are reviewed and referred to specialist services and to other health services as required.

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

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

The food service meets the nutritional needs of the residents with special needs catered for. Family/whānau and EPOAs verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored.

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating. Laundry is undertaken offsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Family members reported a timely staff response to call bells. Security is maintained.

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 meet the requirements of restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical manager is the nominated restraint coordinator and demonstrated knowledge and understanding about this standard and for this role. The facility has a philosophy and practice of no restraint. There were no restraints of enablers in use on the days of audit.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme is managed by a trained infection control coordinator. It aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results shared with all staff. 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	44	0	1	0	0	0
Criteria	1	90	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Residents receive services that meet the consumer rights legislation. The service has developed and implemented policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>The staff were observed communicating with residents in a respectful and courteous manner. On the days of the audit residents were observed being encouraged to be independent, options were provided, and privacy and dignity was maintained. This was confirmed in interviews conducted with EPOAs and family/whānau.</p> <p>The interviewed staff understood the requirements of the Code. Training on the Code is included as part of the induction process for all staff employed and in ongoing annual training, as was verified in staff training records sampled.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the</p>	FA	<p>The interviewed clinical manager and healthcare assistants (HCAs) understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Informed consent is part of the admission process and general consent has been gained appropriately. Signed admission agreements and general consent forms were sighted in the clinical files reviewed. Resuscitation treatment plans and advance directives are also part of the admission process and were</p>

<p>information they need to make informed choices and give informed consent.</p>		<p>sighted in the reviewed residents' records as applicable. Staff were observed to gain consent for daily cares.</p> <p>The interviewed family/whānau and EPOAs confirmed having signed the admission agreements and consent forms as required.</p> <p>Influenza and Covid-19 vaccination consent forms were sighted in residents' files sampled.</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>	<p>FA</p>	<p>Nationwide Advocacy Services pamphlets are given to residents' family/whānau and EPOAs on admission to the service. The residents' information booklet has information on advocacy services and the Code.</p> <p>The clinical manager stated that in the event of a complaint made or any time during service delivery, residents' family/whānau are offered an option of an independent advocate who will be available for support as required.</p> <p>Residents had support of EPOAs. Activated EPOAs were sighted in the sampled files for residents.</p> <p>The interviewed family/whānau and EPOAs were aware of the Advocacy Service, how to access this and the residents' right to have support persons. Interviewed staff understood the advocacy policy and procedure.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service encourages visits from residents' family/whānau and friends. A number of visitors were observed visiting residents on the days of the audit. Visitors are required to follow the Covid-19 pandemic MoH guidelines when visiting the service. Due to current Covid-19 pandemic infection prevention and control measures implemented, visiting is per booking and visitors were not allowed to go into the residents' rooms, they have a space to sit with their family at the reception area.</p> <p>Family/whānau and EPOAs expressed satisfaction with staff attitude when they visited and stated they felt comfortable in their dealings with staff.</p> <p>Residents are assisted to maintain links with their family/whānau and the community by having organised external entertainers visiting the service, and residents can go out on social outings in the van as part of the activities programme. This was observed on the days of the audit and confirmed in interviews with family/whānau.</p>
<p>Standard 1.1.13: Complaints</p>	<p>FA</p>	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the</p>

<p>Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>Code. Information on the complaint process is provided to residents and families on admission and those interviewed said they understood the process. Complaint information (forms, advocacy and HDC pamphlets) were on display in the reception foyer.</p> <p>The complaints register showed that five complaints have been received over the past year. There was documented evidence that each of these had been acknowledged in a timely way, fully investigated and all parties communicated with. Where required actions were taken to reach an agreed resolution. All complaints had been closed. Action plans showed any required follow up and improvements have been made where possible. The BCM is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Family/whānau or EPOAs are provided with an explanation of the consumer rights on admission by the business care manager (BCM) or admitting nurse. This was confirmed in interviews with residents' family/whānau and EPOAs.</p> <p>The Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) posters were prominently displayed on the notice board at the reception area and several areas around the facility. The Code posters were in English and Māori languages. Information on advocacy services, complaints, and feedback forms were available at the reception area. The complaints and suggestion box was at the reception area and accessible to visitors and family/whānau.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>All residents have individual rooms that provide personal privacy, and physical, visual and auditory dignity for residents during care. On the days of the audit, privacy and dignity were observed to be provided as personal cares were being undertaken. Bathrooms had clear signage when in use. Staff were observed respecting residents' personal areas and privacy by knocking on the doors before entry. Family/whānau and EPOAs confirmed that services were provided in a manner that has regard for residents' dignity, privacy, sexuality, spirituality, and choices.</p> <p>Residents are allowed to bring limited personal belongings they can relate to. The personal belongings and property are recorded on admission and are labelled for easy identification. The residents' family/whānau reported that residents receive back their clothes after laundering in a timely manner.</p> <p>Residents are supported to attend to community activities to meet their individual needs. The interviewed staff stated that an escort is provided as and when needed to promote residents' independence. The care plans included documentation related to the residents' 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. All staff have received education on abuse and neglect. The training is provided annually for all staff. This was evidenced in training records sighted. Interviewed staff demonstrated awareness of abuse and neglect and actions to take if required.</p> <p>The interviewed NP, EPOAs and family/whānau have not witnessed or observed any abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Residents who identify as Māori are supported to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into daily practice, as is the importance of whānau. The Māori Health plan in place is current. Reference is made to the Te Whare Tapa Wha Māori model of health, the four cornerstones of health and to whanaungatanga (relationships).</p> <p>Guidance on tikanga best practice is available. Māori cultural advisory is provided through the local DHB and local iwi or kaumatua if required.</p> <p>Whanau of residents who identify as Māori reported that staff acknowledge and respect residents' individual cultural needs. There were three residents who identified as Māori on the days of the audit. Staff have received education on cultural awareness.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents' family/whānau and EPOAs are consulted on residents' individual values and beliefs, including ethnic, cultural, and spiritual during the admission assessment, as confirmed in interviews. Interviewed family/whānau confirmed that individual values and beliefs are respected.</p> <p>There are policies and procedures to guide staff in providing care in a culturally safe manner. The care plans reviewed included residents' individual preferences, required interventions and special needs.</p> <p>The satisfaction survey confirmed that individual needs were being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The service has current policies and procedures that outline the safeguards to protect residents from discrimination, coercion, harassment, sexual, financial or any other exploitation. Residents' family/whānau, including the EPOAs and the NP stated that residents were free from any type of discrimination, harassment, or exploitation.</p> <p>The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. These are included in the employee handbook and are discussed with all staff during the induction period. The registered nurses (RNs) have completed training on</p>

		<p>professional boundaries.</p> <p>Staff demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Elmswood Rest Home encourages and promotes good practice through evidence-based policies that are reviewed regularly and regular internal audits. The service works in collaboration with external specialist services and allied health professionals, for example, wound care specialist and mental health services for older persons where required. The NP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff receive regular education that includes mandatory training topics. This was confirmed by the interviewed staff and staff training records reviewed. The training calendar for the year and education evaluation records were sighted. The RNs have access to external education through the local hospital board, though this was limited over the past year due to Covid-19 pandemic restrictions. Staff have access to online training. Staff reported that they receive support from senior staff as required. Weekly training sessions to discuss different topics in relation to residents' care and regular training workshops with the mental health team were introduced to improve residents' care.</p> <p>The service has introduced the 'Stop and Watch' tool to escalate concerns or changes in residents' condition in a timely manner. The 'ISBAR' communication tool was also introduced for use by the clinical team to improve communication during handover, NP rounds and reporting acute changes in residents' conditions.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Interviewed family/whānau and EPOAs stated they were kept well informed about any changes to 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 evident in residents' records reviewed. The NP confirmed that meetings with family/whānau are arranged by the clinical manager if requested or when required.</p> <p>Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code.</p> <p>The clinical manager stated that during the admission process, interpreting services are offered if required. Access to interpreter services is through the local district hospital board. Staff knew how to access interpreter services, although reported this was rarely required due to most residents and family/whānau able to speak English. Family/ whānau and EPOAs are used for those with communication difficulties. Verbal cues and gestures are some of the methods used for residents who had</p>

		communication difficulties. Email communication records and family contact records were sighted in the residents' files sampled.
<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>	FA	<p>Elmswood Rest Home (Elmswood) is part of Oceania Healthcare Limited (Oceania). Oceania has a documented mission, vision and values statement, which reflect a person/family-centred approach to all residents. The mission, vision and values are displayed at the front entrance of the facility. Interviews with staff and training records confirmed that these are communicated to staff during orientation and annual training. Elmswood has a documented facility specific budget, key performance indicators (KPIs) and business objectives, as sighted on audit.</p> <p>The Oceania executive management team provides written and physical support to the facility, with communication occurring at least monthly. Reports about events, occupancy, staffing and progress toward meetings clinical and business key performance indicators (KPIs) are shared between Oceania corporate office, senior management and the BCM. These were sighted. The key performance indicator (KPI) reports are used for benchmarking Elmswood's data with similar sized secure facilities operated by Oceania. These results are discussed at monthly meetings with the regional operations and regional clinical managers. The BCM has been in this role for over four years, having previously worked as an administrator in the facility for two years. The BCM has completed Oceania management training and has a previous background in business management and human resources. The clinical manager (CM) supports the BCM and has been in the role for six weeks. The CM holds a current RN practising certificate and is supported by the Oceania regional CM. This person has many years' experience working in dementia services.</p> <p>Elmswood is certified to provide dementia level of care for up to 38 residents. The facility was full with all 37 available beds occupied at the time of this audit (one of the 38 bedrooms is used for storage). All residents had been assessed as requiring dementia level care and were over the age of 65 years.</p> <p>The facility holds contracts with the district health board (DHB) for the provision of dementia care, day care and respite care for up to 38 residents. At the time of the audit there were no residents accessing the respite or day care services.</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</p>	FA	<p>When the BCM is absent, the CM carries out all the required duties under delegated authority, with support from the regional clinical manager, regional operations manager and the BCM from a nearby Oceania facility. During absences of key clinical staff, the clinical management is delegated to the most senior and experienced RN. Staff reported the current arrangements work well.</p>

<p>efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</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>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes for example, management of clinical incidents including infections and complaints, regular satisfaction surveys of relatives and staff, internal audit activities and monitoring the effectiveness of any actions taken as a result of the audit. The BCM, CM and other staff as relevant, have well established system for identifying and implementing quality initiatives at least every three months. There are many examples of initiatives which benefit residents. The outcomes of this are reflected in the continuous improvement rating in 1.2.3.5.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at various staff meetings.</p> <p>Staff reported their involvement in quality and risk management activities development and implementation of initiatives, and audit activities. Where service monitoring or feedback indicates shortfalls, staff are involved in finding solutions and applying corrective actions to address these.</p> <p>Family satisfaction surveys are completed every six months. The most recent survey (with feedback from four of 12 families surveyed) revealed high levels of satisfaction and one concern about personal laundry.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process with relevant NASC requirements for younger people. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p>
<p>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 manner.</p>	<p>FA</p>	<p>Staff enter all adverse and near miss events into an integrated resident information management system. This incident/accident data is collated online, analysed for trends and benchmarked across comparable services. All of the events sampled (that involved a resident) contained evidence of follow-up by a registered nurse. Each event was clearly described and showed that family and/or medical professionals had been notified if required. Where needed events had been investigated and preventative action plans developed to minimise or eliminate recurrence. There is a finding in Standard 1.3.4 related to the timing of neurological observations for suspected head injuries after unwitnessed falls.</p> <p>The BCM described essential notification reporting requirements, including for pressure injuries. They advised the only notification made to the Ministry of Health, and DHB since the previous audit was the</p>

		change in clinical manager in January 2022.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required.</p> <p>Six staff files reviewed (clinical manager, one RN, one activities coordinator, one kitchen assistant, and two healthcare assistants (HCAs)) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of practising certificates for all regulated health staff, for example, RNs, GPs, physiotherapist, nurse practitioner and pharmacist, was maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period and then annually.</p> <p>All staff are regularly assessed against a range of competency topics, as demonstrated by marked and signed competency questionnaires/assessments.</p> <p>Continuing education is planned on an annual basis, and also includes each staff member mandatorily attending a 'GEM' study day each year. This study day presents a suite of education topics, such as consumer rights, emergency procedures, infection prevention and control, restraint, continence, nutrition, safe handling and transfers.</p> <p>Elmswood staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Of the 16 HCAs, seven have achieved level 4 of the national certificate in health and wellness, five are at level 3, two at level 2 and two at level 1. Fifty percent of staff have completed the Limited Credit Programme' (LCP) in dementia training as required in the ARRC agreement. RN specific training viewed included for syringe drivers, wound care, and first aid. One of the three currently employed RNs was confirmed as maintaining their competency in carrying out interRAI assessments.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The rosters sampled confirmed that four HCAs plus one RN are onsite every morning and afternoon shift; that is, two HCAs in each wing which accommodates 17-18 residents. Three level 4 senior HCAs are rostered on each night. The CM and BCM are on site for normal business hours Monday to Friday.</p>

<p>and/or experienced service providers.</p>		<p>Interviews confirmed that staffing levels are adjusted as needed to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. This was supported by family members interviewed. The four-week roster cycle and interviews also confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</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>	<p>FA</p>	<p>There is an electronic information management system in use for all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with the NP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database and assessments uploaded into the resident information management system. Records were legible with the name and designation of the person making the entry identifiable. Staff have individual passwords to access the electronic records.</p> <p>Archived records are held securely and are readily retrievable in the resident information management system. Residents' files are held for the required period before being destroyed. Staff have individual passwords to access the resident's electronic records. No personal or private resident information was on public display during the audit. Destruction bins were available for confidential documents for disposal.</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>	<p>FA</p>	<p>Residents' entry into the service is facilitated by the BCM and the clinical manager (CM) in a competent, timely and respectful manner. There is an admission policy and procedure to guide staff. Access processes and entry criteria, assessment and entry screening processes are documented in the service's information booklet. The processes are explained to prospective residents' family/whānau of choice or EPOAs, local communities and referral agencies when needed. Services provided are clearly stated on the services website and information booklet. Prospective residents' family/whānau are encouraged to visit the service prior to admission and are provided with written information about the service and the admission process. A tour of the facility is conducted at that time if desired.</p> <p>The sampled files confirmed that residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. NASC assessment forms with the documented level of care were sighted in the residents' files sampled.</p> <p>Family/whānau and EPOAs interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Residents were admitted with the consent of their EPOAs. Signed admission agreements were sighted in the residents' records reviewed.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The residents' discharge or transfer is planned and coordinated by the CM and RNs. An escort is provided as appropriate. The service uses the services own system to facilitate transfer of residents to and from acute care services. Open communication between all services and the residents' family/whānau or EPOA was evident in the transfer records sighted. The transfer records for a resident transferred to acute services demonstrated that appropriate information was provided for the ongoing management of the resident. All referrals were documented in the progress notes. The EPOA of the resident reported being kept well informed during the transfer of their relative.</p> <p>The CM stated that 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's EPOA. The service agreement has a clause related to when a resident's placement can be terminated, and this is explained to the resident's family/whānau or EPOA on admission.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service has a safe electronic medication management system in place that was observed on the days of the audit. The medication management policy is current and identified all aspects of medicine management in line with safe practice guidelines and current legislative requirements. Staff who administer medication had current medication administration competencies. A list of medication administration competent HCAs was maintained and was accessible to all staff.</p> <p>The RN observed administering medicines demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. Medicines were stored safely in the locked cupboards and medicine trolley. Staff have individual passwords to access the electronic medicine records. The medicine fridge temperature and medicine room temperature were monitored, and records were maintained.</p> <p>Medications are supplied to the service in a pre-packaged format from a contracted pharmacy. The CM or RN completes the medication reconciliation upon residents' readmission from an acute service and when medication is received from the pharmacy. Clinical pharmacist input is provided on request. Unwanted medicines are returned to the pharmacy in a timely manner. There were no expired medicines in stock.</p> <p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. A current staff signature register was sighted.</p> <p>The CM reported that any medication errors are documented, and appropriate investigations completed. The recorded medication errors were investigated, and corrective action plans were implemented.</p> <p>Three-monthly medication reviews were consistently completed by the NP, as evidenced on electronic</p>

		<p>medicine charts reviewed. Dates were recorded on the commencement and discontinuation of medicines. Allergies and sensitivities were consistently documented on the electronic medicine charts reviewed. Evaluation of pro re nata (PRN) medicines administered were completed consistently.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Meals are prepared offsite at another facility across the road owned by the same organisation and delivered to the facility daily. The kitchen assistants on site are responsible for serving the food. Food is transported to the respective dining rooms in 'baine maries'. The kitchen assistants have completed basic food safety training. Food, fluid and nutritional needs of the residents are provided in line with recognised nutritional guidelines for older people. There is a summer and winter menu that rotates on a four-weekly cycle. The menu was reviewed by a qualified dietitian on 6 October 2021. The service operates with an approved and current food safety plan and registration issued by the Ministry of Primary Industries expiring on 22 March 2022.</p> <p>Residents' nutritional needs were identified on admission and a dietary profile developed. Special dietary requirements, including likes, dislikes and allergies were identified and accommodated in the meal plan. Nutritional supplements were provided for residents with loss of weight issues. Residents always have access to food and fluids to meet their nutritional needs.</p> <p>The meals were served in dining rooms in each unit and residents who do not want to go to the dining rooms can have meals served in their room as desired. Food, fridges and freezer temperatures were monitored appropriately, and recorded as part of the food control plan.</p> <p>Residents' family/whānau and EPOAs reported satisfaction with the food service, and this was verified in the satisfaction surveys sighted and meeting minutes sighted. On the day of the audit residents were given enough time to eat their meals in an unhurried fashion.</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>	FA	<p>The CM stated that a referral can be declined if the prospective resident does not meet the entry criteria or there is no vacancy. The local NASC is advised to ensure the prospective resident/family/whānau are supported to find an appropriate care alternative. The prospective resident/family/whānau will be advised of the reason for the decline and will be informed of other alternative services available or referred to NASC as appropriate.</p>
Standard 1.3.4: Assessment	PA Low	<p>Nursing assessments were completed on admission using the organisation's initial assessment tool. The</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>assessed areas included pain, falls risk, pressure area risk, nutrition, continence, personal cares and behaviour, as a means to identify any deficits and to inform care planning within 24 hours of admission. Behaviour assessments including triggers and ways to manage the behaviours were completed for all residents in the files sampled for review.</p> <p>Neurological observations were completed following unwitnessed falls, although the frequency did not comply with the organisation's policy.</p> <p>In six of the seven files sampled for review interRAI assessments were completed within three weeks of admission. However, one file did not have evidence of interRAI assessment completed within three weeks of admission. In interview, the CM stated that the interRAI assessment not sighted was completed and was not uploaded in the resident's organisational information management system. InterRAI assessments were completed routinely six-monthly and when there was significant change in resident's condition. The interRAI software system could not be accessed on the days of the audit. The sample of care plans reviewed had an integrated range of resident-related information.</p> <p>Residents' families/whānau and EPOAs confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed, with the exception of one resident's care plan sampled for review where the initial interRAI assessment could not be evidenced (Refer to 1.3.4.2). The resident's EPOA, the HCAs and observations confirmed that the care that the resident is receiving is adequate to address their identified needs. Behaviour management care plans including triggers and strategies to manage the behaviours were completed in the files sampled for review.</p> <p>Service integration was evidenced in the care plans with progress notes, activities assessments, medical and allied health professionals' notations clearly written, informative and relevant. Changes in care required were documented and verbally passed on to relevant staff at the start of each shift.</p> <p>Residents' family/whānau and EPOAs confirmed participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in</p>	<p>FA</p>	<p>The sampled residents' care plans, observations and interviews verified that 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. Behaviour monitoring charts were completed for any behaviours of concern and the behaviour management plans implemented were</p>

<p>order to meet their assessed needs and desired outcomes.</p>		<p>followed.</p> <p>Significant changes were reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the NP in the interview conducted.</p> <p>Monthly nursing observations monitoring was completed for all residents, and records were maintained. HCAs and RNs confirmed that care was provided as outlined in the care plans.</p> <p>A range of equipment and resources was available, suited to the level 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>The activities programme is provided by a diversional therapist (DT) who was on leave on the days of the audit, and an activities assistant. The activities assistant was covering during the absence of the DT and is in the process of completing an NZQA approved dementia training programme.</p> <p>Residents' activity needs are assessed as part of the admission process with input from the resident's family/whānau to ascertain the resident's needs, interests, abilities, and social requirements. The DT completes activities assessments, and the RNs complete the leisure care plans as part of the long-term care plans with input from the activities team. The leisure care plans reviewed evidenced a 24-hour approach to activities including aspects of the resident's life and past routines. The activities programme is regularly reviewed to help formulate an activities programme that is meaningful to the residents through two-monthly family meetings and satisfaction surveys.</p> <p>The activities participation register was completed daily as evidenced in the records reviewed. The residents' activity needs were evaluated when there was a significant change in participation and as part of the formal six-monthly interRAI assessment and care plan review.</p> <p>A monthly calendar was posted on the notice boards around the service and weekly activities were documented on the white boards in each unit. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. The activities on the programme were specific to the needs and abilities of the people living with dementia. Individual, group activities and regular events are offered. Residents were observed participating in a variety of activities on the days of the audit. Activities on the programme included walking groups, exercises, baking, news discussion, ladies club, men's club, ball games, 'sundown' therapy, 'cocktail hour', splashing in the pool, blowing bubbles, weekly church services, music, external entertainment, and birthday celebrations. The interviewed residents' family/whānau and EPOAs confirmed satisfaction with the variety of activities and the programme.</p> <p>The activities assistant stated that activities are adapted to meet the residents' needs and mood. The residents were observed to be given an opportunity and choice to participate or not. The residents were observed walking freely in and out of the secure gardens. The staff were observed communicating with</p>

		residents in a respectful manner during the activity sessions. Activities are offered at times when residents are most physically active and/or restless.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes by the HCAs. The HCAs reported that any changes noted are reported to the RN or CM. This was confirmed in the handover observed and in residents' records reviewed. The residents' care plans sampled for review evidenced that routine care plan evaluations were completed every six months following the six-monthly interRAI reassessment, or as residents' needs change. Where progress was different from expected, changes were made to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated for wounds, skin, and urinary tract infections. Multi-disciplinary review meetings were conducted three-monthly with the EPOAs and the nursing team. Residents' family/whānau interviewed confirmed being involved in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the NP, CM and RNs send a referral to seek specialist input. Evidence of EPOA involvement in referrals was sighted in residents' records sampled. Copies of referrals included referrals to the mental health team, radiology, and dietitian. The family/whānau and EPOAs 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 the public hospital in an ambulance if the circumstances dictate. Urgent referral records were sighted in the residents' files reviewed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances,	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is more than adequate provision and supply of protective clothing and equipment for use during outbreaks or any clinical procedures and staff were observed using these.

generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 03 May 2022) was publicly displayed.</p> <p>Effective systems are in place to ensure the residents' physical environment and facilities are fit for purpose and safely maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. For example, the two hoists were checked and serviced in July 2021. The environment was hazard free and resident safety was being promoted. Residents were seen to be readily accessing several external areas. Gardens and grounds were well maintained, offering good shade, and furnished with safe seating appropriate to the resident group.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. This was confirmed by review of the maintenance request book. A full time maintenance person is employed who also provides maintenance services in another nearby Oceania facility and village. Family members expressed satisfaction with the environment and all residents appeared happy and settled inside and outside the home.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 14 bedrooms with toilets plus one room with an ensuite toilet and shower. Residents without a toilet attached to their rooms, have ready access to toilets and shower rooms close to their bedrooms. There are additional toilets for residents located close to recreation rooms in each wing, and a separately designated staff and visitor toilet. Regular upgrading and replacement of stained or worn floor coverings in toilets and bathrooms is scheduled and occurring.</p> <p>Hot water temperature monitoring is occurring each month - records sighted showed temperatures below 45 degrees Celsius.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other possessions displayed. Each bedroom door is painted a different colour to assist residents in identifying their rooms and ablution areas are painted a dark blue colour. There is room to store mobility aids and wheelchairs within each residents' bedrooms and the two hoists are safely located when not in</p>

consumer group and setting.		use. Staff and family expressed satisfaction with bedrooms.
<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>Communal areas are available for residents to engage in activities. Each of the two wings has an easily accessed dining room and separate lounge areas. The dining and lounge areas were large enough to accommodate residents with mobility aids and staff who were attending to them. Residents were observed to be accessing other quiet areas as they desired. Furniture was in good condition and appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is undertaken off site by a contracted provider, and personal laundry by family members if they prefer. Care staff were observed to be effectively and safely managing dirty/clean flow and handling of soiled linen. The families interviewed said they had no concerns about the laundry service. There was one minor concern expressed in a recent relative survey (refer 1.2.3)</p> <p>Laundry and cleaning services are monitored via the internal audit system, daily visual inspections, and family and staff feedback. The small cleaning team have received appropriate training (level 3 cleaning certificate) and all staff complete chemical safety training, as confirmed by staff interviews and training records. The service rosters one dedicated cleaner on each day of the week for seven hours a day. All areas in the facility were spotless. Chemicals were observed to be safely managed and all decanted into clearly labelled containers, for example, the cleaner was vigilant about not leaving the trolley with chemicals unattended whilst it was in use. The trolleys are stored in a lockable cupboard and when not in use. Family members said the facility was always clean and never odorous when they visited.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 28 April 1987. A trial evacuation takes place six-monthly with a copy sent to the Fire and Emergency New Zealand (FENZ) the most recent being on 30 September 2021. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. It was reported that no emergency or security events had occurred since the previous audit.</p> <p>Sufficient supplies for use in the event of a pandemic and/or civil defence emergency, including PPE, food, water, blankets, mobile phones and gas BBQs were sighted and meet the National Emergency</p>

		<p>Management Agency recommendations for the region. Two hundred litres of potable water are stored inside and a large water tank is located on site. Emergency lighting and fire suppression systems were being regularly checked and tested.</p> <p>Staff were observed to be responding to call bells. These are only activated by residents stepping on bell mats placed by their beds, or by staff in an emergency.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by wall panel heaters in residents' rooms and heat pumps/air-conditioning units in the communal areas. Areas were well ventilated throughout the audit and staff and families said all areas in the home are maintained at a comfortable temperature year round.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external specialists. The infection control programme is reviewed annually and was last reviewed on 2 February 2022.</p> <p>The RN is the designated infection control coordinator (ICC), whose role and responsibilities are defined in their job description. The ICC is supported by the CM. Infection control matters, including surveillance results, are reported monthly to all staff, and tabled at the management and staff meetings. The IPC committee includes the BCM, CM ICC, an HCA, activities assistant and a cleaner.</p> <p>There is signage at the main entrance to the facility requesting anyone who is or has been unwell with flu like symptoms in the past 48 hours, not to enter the facility. The interviewed staff understood their responsibilities on how long they must stay away from work if they have been unwell. Covid-19 contact tracing information was maintained and symptoms checks were completed for all visitors at the reception area.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	FA	<p>The ICC is newly appointed and has been in this role for one week. The ICC has appropriate skills and knowledge for the role. The ICC is supported by the CM. They have attended relevant infection prevention and control education, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the NP and public health unit, as required. The ICC has access to residents' records and diagnostic results to</p>

infection control programme and meet the needs of the organisation.		<p>ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. Adequate resources were sighted on the days of the audit. Updated information on Covid-19, including vaccination information was available and easily accessible to staff and residents' family/whānau. All residents have received the Covid-19 vaccination. Vaccination consent forms signed by EPOAs were sighted in the residents' files sampled for review.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed in June 2020 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. Hand washing and sanitisers were readily available around the facility. The interviewed staff demonstrated 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>	FA	<p>Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. There was evidence that additional staff education has been provided in response to the Covid-19 pandemic.</p> <p>Education with residents is on a one-to-one basis for any infections where possible and in groups during family meetings. This included reminders about handwashing and updates on Covid-19 pandemic infection prevention and control measures. Covid-19 pandemic infection prevention and control updates were also provided to residents' family/whānau through email communication. This was verified in residents' meeting minutes, short-term care plans sighted and in interviews with family/whānau.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, ear nose and throat and the upper and lower respiratory tract. Infection reports are completed for all infections and the ICC reviews all reported infections. New infections and any required</p>

<p>carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>management plans are discussed at handover, to ensure early intervention occurs. This was confirmed in the handover observed and in staff interviews.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Regular IPC audits were completed, and corrective actions were implemented as required. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. There have been no infection outbreaks reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 if they should ever be required. The CM is the appointed restraint coordinator. This person demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. They provide staff education, support and oversight to ensure there is no restraint used.</p> <p>No residents were using restraints or enablers at the time of this audit. The service was maintaining its philosophy and practice of no restraint interventions with their dementia residents. Falls and risks are minimised by use of low beds, judicious prescribing of medicines and sensor/bell mats when the resident is in bed.</p> <p>If a resident required a restraint intervention for safety, it is most likely their level of care would be re-assessed.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as</p>	PA Low	<p>The CM reported that interRAI assessments are completed using the interRAI software system and the assessment records are uploaded into the organisation's electronic residents' information management system. Six of seven resident files sampled contained interRAI assessment outcome scores which were reflected in the care plan goals and interventions. These also showed evidence of family/whānau input.</p> <p>One resident who was admitted within the past four months did not have evidence of initial interRAI assessment development within three weeks of admission. The CM reported that the interRAI assessment for this resident was completed. However, this could not be verified as the interRAI assessment records could not be accessed on the days of the audit. Efforts to contact the providers of the InterRAI system were unsuccessful on the days of audit. An email requesting access for the CM and the new RN from Elmswood the previous week had not been responded to. The service had not been able to access InterRAI to confirm the level of care for each resident, or check</p>	<p>Five out of five incident reports related to unwitnessed falls did not have neurological monitoring completed at the frequency required by organisation's policy. The policy stated that neurological observations will be completed every 30 minutes for the first two hours then half hourly for the next four hours then hourly for four hours and four-hourly until 24 hours is completed. The sampled</p>	<p>Ensure post unwitnessed falls neurological monitoring is completed at the frequency required, as per organisational policy.</p> <p>Ensure interRAI assessments are</p>

<p>the basis for service delivery planning.</p>		<p>when their 6 monthly interRAI reviews were due since December after the RNs who did the interRAIs had left their employment. The newly employed RN with interRAI competencies had been at Elmswood for one week. The CM reported that the interRAI assessor will be allocated time to complete the interRAI assessments to ensure that assessments will be completed in a timely manner. An additional two new RNs are to be enrolled for interRAI training. The other six files sampled for review had the initial interRAI assessments completed in a timely manner where applicable and records uploaded in the residents' organisational electronic information management system.</p> <p>Incident forms were completed electronically for residents following a fall. However, post fall neurological observations for unwitnessed falls were not completed as per the organisation's policy. The BCM reported that the post fall monitoring policy for unwitnessed falls is being reviewed.</p>	<p>records showed that the neurological observations were completed but not at the recommended frequency.</p> <p>One resident's file out of seven files sampled for review did not have evidence of initial interRAI assessments completed.</p> <p>The interRAI assessment records in the interRAI software system could not be accessed on the days of the audit. The service did not have access to the interRAI software system. The CM stated that the interRAI assessments were last completed in December before the previous RN left.</p>	<p>completed in a timely manner.</p> <p>Ensure the service has access to interRAI software system.</p> <p>90 days</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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	CI	<p>Elmswood Rest Home have a well implemented practice and processes for identifying and improving the lives of their residents based on clinical indicators and what they learn from their quality monitoring. In the last 12 months four quality improvement initiatives have been started and are ongoing. For example, the initiative to improve the communication and act promptly on any changes observed in any resident. The handover process was changed in April 2021 to a ‘walk and talk’ exercise. HCAs began using the ‘Stop and Watch’ method for communicating up to RNs, and the ‘ISBARR’ tool was also introduced. This facilitated the RNs on each shift to see and hear exactly what was changing for residents and then implement actions such as notifying GPs, implementing closer observations and monitoring records. This was reviewed every three months and is now a permanent process. Deterioration in residents is now clearly and quickly identified and staff on all shifts can account for what is reported and what is being done as a consequence.</p> <p>An activities initiative ‘Ball drumming’ commenced in late October 2021. By directing residents to use sticks to drum large exercise balls, the goal was to improve physical fitness, reduce frustration, and experience a fun group activity. This regular activity has been eagerly taken on by residents who now recognise what’s going to happen when the balls come out. Staff described a reduction in resident’s agitation following the activity, but this and any improvements in physical fitness or reduction in falls is</p>	<p>Resident welfare is improved through continually trying new approaches to service delivery. These ideas are often prompted by trends in clinical indicators and what staff have learned from quality monitoring.</p>

		<p>still being studied.</p> <p>Another initiative 'opening the doors between each wing' allowed residents on each side to interact with each other and increased the number of areas they could 'wander and explore' started in July 2021. This initiative was halted due to the August 2021 and January 2022 Covid-19 Delta and Omicron alerts which had aged care facilities go back into managed visiting. The connecting area between the two wings can no longer stay open. Initial outcomes were reported as encouraging, particularly when relatives visited and the resident could walk to the external facing front door with their family member to say goodbye, rather than at the door of their unit which could result in residents becoming frustrated and trying to follow them out.</p> <p>The trial of a 'Wibo' bed for a resident who was developing pressure injuries in February 2021, demonstrated that the bed with built in pressure relieving properties, interrupted any worsening of skin break down. Photo evidence and notes made each month after the trial started was sighted. The service purchased the bed which is still being used by the same resident, and they are keen to trial it with residents identified as high falls risks or skin integrity issues.</p>	
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End of the report.