

Oceania Care Company Limited - Addington Rest Home

Introduction

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

The audit has been conducted by 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: Addington Rest Home

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care

Dates of audit: Start date: 15 February 2022 End date: 16 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: 83

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Addington Rest Home (Addington Gardens) is owned and operated by Oceania Healthcare Limited and provides rest home, hospital, dementia, and residential disability (physical) care for up to 97 residents in Christchurch.

This unannounced surveillance audit was conducted against the relevant Health and Disability Services Standards and the services contracted by Canterbury District Health Board, at the red traffic light setting during the Covid-19 pandemic. The auditors reviewed residents' and staff files, organisational policies, records, and the environment, and included interviews with residents, families, regional and facility management, staff, and a general practitioner.

One area requiring improvement was identified relating to closure of complaints. Previous corrective actions related to the facility, medication management and activities plans have been adequately addressed.

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.		Some standards applicable to this service partially attained and of low risk.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------------------------

Open communication between staff, residents and families is promoted, with frequent contact documented. There is access to interpreting services if required.

Concerns and complaints are recorded and addressed in accordance with the Code of Health and Disability Services Consumers' Rights.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Oceania Healthcare Limited is the governing body responsible for the facility. Since the previous audit, a new Oceania CEO has commenced in the role. The business and care manager (BCM) is experienced and has overseen the facility for nine years. A regional management team and clinical manager provide support. Regular comprehensive monitoring of the services is undertaken, with information reported to the governing body.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions identified and implemented where necessary. Actual and potential risks, including health and safety risks, are identified, and mitigated. Policies and procedures are managed nationally and support service delivery to all residents, including those younger people with disabilities.

The recruitment, appointment, orientation, and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential residents and their family/whānau.

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

The planned activity programme provides residents with a variety of individual and group activities and activities for younger people with disabilities are provided. The programme enables residents to maintain their links with the community and a facility van is used for outings.

Medicines are safely managed and administered by staff who are competent to do so. No residents were self-medicating at the time of audit.

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

Safe and appropriate environment

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

Standards applicable to this service fully attained.

There is a current building warrant of fitness. A reactive and preventative maintenance programme is implemented, including electrical and biomedical testing. There have been no changes to the building footprint.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. Seven enablers for five residents were in use at the time of the audit. There has been no restraint used in the past nine months.

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.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	0	0	0
Criteria	0	38	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	<p>Concerns and complaint processes meet the timeframes required in Right 10 of the Code of Health and Disability Services Consumers' Rights. Information about the complaint process is provided and explained to residents and families on admission with the hard copy forms readily available to people in the reception area. Reminders about the complaint process are noted in resident meeting minutes. There are no known Health and Disability Commission complaints, or complaints reported to other external agencies.</p> <p>Seven complaints have been recorded over the previous year. Concerns are also logged and fully responded to. The organisation is transitioning to recording all complaint information into a comprehensive electronic system. This process has just commenced and will also act as the complaint register, enabling tracking of progress and follow up. The BCM is responsible for the management of complaints in the facility, with detail reporting each month to the national QCAM (quality, compliance, audit management) team.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	Staff are aware of the need to keep residents and family members well informed about any changes in the resident's status. Several examples were reviewed in relation to incidents or accidents, or when urgent medical review was required. Incidents are reported electronically, which includes a box to record communication with the resident or their family. Further detail is included in the electronic record progress note section. The business care manager (BCM) is readily available ('open door'), and the clinical manager is active throughout the facility

<p>provide an environment conducive to effective communication.</p>		<p>should residents wish to raise any issues. Positive interactions were observed during the audit. Staff knew how to access interpreter services, although reported that this was rarely required.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Addington Rest Home (Addington Gardens) is owned and operated by Oceania Healthcare Group. It is one of five facilities operated by Oceania Healthcare Ltd in the Christchurch area. The governance structure includes a board, executive leadership team (including a new CEO in 2021), operational committees and regional support teams. Business and quality plans reflected the organisation's values and objectives and are developed by the BCM to reflect the service's needs. A sample of monthly and quarterly reports and meeting minutes were provided to support performance monitoring, including financial performance, changes in risks and clinical and facility issues.</p> <p>The BCM is a very experienced facility manager, having led this service for nine years. She holds a current annual practising certificate and maintains currency through the various forums (now mostly online) provided through Oceania or the Aged Care Association. A clinical manager (CM) was appointed in mid-2021, having previously worked in short term CM roles for the organisation.</p> <p>The service provides dementia, hospital, and rest home care for up to 97 residents. There were 83 residents in the facility at the time of audit. This consisted of 18 dementia care residents, 30 rest home level care residents, one respite care and 34 hospital level care which includes five residential disability in dual purpose beds. Twenty-two of the dual-purpose beds are presently under occupation right agreements (ORAs). The layout of the building enables staff to be rostered across two wings, with largely separate staffing arrangements for the dementia unit. Five residents under the YPD agreement are included in the occupancy numbers.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a well-established, planned and implemented national quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint. Data collected within the facility is analysed and compared over time. Specific meetings and satisfaction surveys including for younger people with disabilities, are undertaken. The organisation uses a range of audit and survey data to benchmark its service against other Oceania facilities and to inform improvement plans.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of the range of quality indicators and related information (eg, CM month end reports) and trends are discussed. Relevant learnings are shared through the regular quality and staff meetings and internal memos. Meeting minutes confirmed a consistent record of quality related matters. Internal audits are undertaken in accordance with the quarterly national schedule. Examples reviewed included medication (four times per year), falls, personal care, admission</p>

		<p>processes and of staff records. Each audit is scored for its compliance and compared and reported as a key indicator. Corrective actions are developed and implemented to address any service shortfalls, including from internal audits.</p> <p>Resident and family satisfaction surveys are completed annually for all residents who wish to respond. Interviews with residents indicated a good level of satisfaction with the service, including for the food service. The last survey was completed in October 2021, with resident meeting minutes referencing results and subsequent discussion. Overall, there is a high level of satisfaction expressed in all domains in the 20 surveys returned.</p> <p>Organisation-wide policies and procedures are managed centrally by Oceania Healthcare Ltd, are controlled, and based on best practice. Those viewed at this audit were current or presently under review.</p> <p>The BCM described the processes for the identification, monitoring, review and reporting of risks and development of risk mitigation strategies. She is familiar with the Health and Safety at Work Act (2015) and has implemented its requirements. A current hazard register identifies health and safety risks throughout the facility and grounds and includes staffing. The health and safety committee meets monthly, with staff engagement. Minutes of meetings were reviewed, and risk ratings associated with different risks and hazards are recorded.</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>	FA	<p>Staff document adverse and near miss events on an electronic form on the intranet. Those interviewed were aware of the required reporting processes. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Where open disclosure or notification to the family or EPOA is indicated, this was recorded on the electronic system and in the progress notes as appropriate. Adverse event data is collated, analysed, and reported to via the quality and staff meetings.</p> <p>The BCM described essential notification reporting requirements, including for pressure injuries, Worksafe NZ and section 31 notifications. There have been two of these notifications made to the Ministry of Health in relation to unsatisfactory staffing levels in 2021. The CM also advised of a complaint made by the facility to the District Health Board, about the transfer information received for a resident who was returning to the facility following a hospital stay.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>Human resources management implemented at Addington Gardens is based on good employment practice and relevant legislation. There is central support for human resource management, with the initial processes now managed electronically. The electronic application process ensures all relevant documents are uploaded prior to selection of the applicant for interview. The recruitment process includes referee checks, police vetting, mandatory drug testing and validation of qualifications and practising certificates (APCs), where required. A</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>	<p>sample of thirteen staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained in hard copy files. Each staff member also has a well maintained and separate hardcopy training file.</p> <p>Staff orientation includes all necessary components relevant to the role. Each person receives a workbook and assessment which is reviewed and discussed with the employee at the end of the orientation period. Staff are buddied, usually in one area, until they are confident in the required tasks. Completion of orientation is recorded on the hard copy staff record, together with certificates of completion for mandatory training, New Zealand Qualification Authority (NZQA) certificates at levels two, three and four and any online Health Learn modules. A staff member is the internal assessor for the NZQA unit standards programme.</p> <p>All but one staff member working in the dementia unit have completed the required NZQA level four dementia limited credit programme within the prescribed timeframe. An individualised learning programme has been put in place to support this staff member to work towards achieving the unit standard requirements of the provider's agreement with the DHB and has commenced the level two foundation unit standards. The individual programme includes accessing other programmes such as 'walking in another's shoes' in the interim.</p> <p>Records reviewed included performance appraisals completed over the previous twelve months for those staff employed for longer than one year. Continuing education is planned on an annual basis, including a programme covering mandatory training requirements and education relevant to residents with disabilities. Specific programmes are provided for health care assistants, registered nurses, and non-clinical staff. This includes an Oceania half or whole day study session for non-clinical and clinical staff. A programme of 'comprehension and competencies' are completed relevant to the role – examples included hand hygiene, knowledge of Covid-19 and health and safety. A basic first aid course is scheduled for March 2022, with 24 staff booked to attend (new staff and those staff requiring revalidation). The programme is undertaken by all staff.</p> <p>There is a well-maintained system to manage annual practising certificates for staff and contractors who require them. This includes a recently appointed nurse practitioner who will share the role with another facility. Eight trained and competent registered nurses are maintaining their annual competency requirements to undertake interRAI assessments, with another booked on the next scheduled programme. Some external face to face training has been delayed due to Covid-19.</p> <p>Registered nurses are offered the option of undertaking the Oceania professional development and recognition programme (PDRP), although only one nurse at the site is presently engaged in this. Oceania Healthcare also offers its own competency programme (CAP course) for nurses seeking registration by the Nursing Council of New Zealand. Several staff are working at level four through recognition of prior learning and as a result of their overseas nursing registration. Addington Gardens has also supported a 'NetP' role and will seek another entry to practice nurse in the second half of the year.</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>	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 facility adjusts staffing levels to meet the changing needs of residents. After hours, the BCM and CM are available on a call roster for the facility or care queries. Staff reported good access to advice and support when needed.</p> <p>Care staff interviewed reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed, and the satisfaction survey supported this.</p> <p>Observations and review of the master week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Flexi shifts allow some additional hours to be allocated at busy times. There are some full-time equivalent (FTE) deficits and roster gaps noted for some caregiving shifts, which is presently mitigated by lower occupancy and the ability to use flexi shifts to maintain staffing levels.</p> <p>Recruitment is ongoing, however staffing and recruitment is recognised as a risk across the wider organisation. Reorganisation of the nurses' station (almost completed) and reallocation of staff across two wings has provided better distribution of staff, including registered nurses for both the swing beds and occupational rights apartments (ORAs). The dementia unit staffing levels are separately maintained. Staff are trained in first aid (see previous comment).</p> <p>Activities across the whole service are provided by a mix of diversional therapist and activities coordinators providing 100 hours of support each week. The programme includes some evening and weekend hours in the dementia unit.</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 was current and identified 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. Allergies or the presence of no known allergies were recorded in all medication charts reviewed and the previous corrective action related to this has been addressed. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the</p>

		<p>recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner should the need arise.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a qualified chef and kitchen team and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan which is current. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The chef 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. The dietary profile is reviewed and updated six monthly and any changes communicated to the kitchen staff. The chef, when interviewed, confirmed knowledge of the dietary needs of residents including their likes and dislikes.</p> <p>Meals are served in the dining room or in the resident's room if they prefer. A buffet style breakfast is served for those residents who are independent; this was appreciated by the residents interviewed.</p> <p>Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet residents' nutritional needs, is available.</p> <p>Resident satisfaction with meals was high as confirmed by resident interviews and review of resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
Standard 1.3.6: Service Delivery/Interventions	FA	Documentation, 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

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>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. Newly introduced weekly team meetings allow for case discussion of any resident whose needs are changing.</p> <p>A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs such as air mattresses, sensor mats and hoists.</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 currently provided six days a week by one trained diversional therapist and an activities assistant.</p> <p>A social assessment and life 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. All residents' files reviewed, including those in the secure dementia unit, contained a lifestyle plan detailing their activity needs and wishes. Residents with behavioural needs have a care plan in place to meet their needs and the corrective action raised at the previous has been addressed. The resident's activity needs are evaluated by assessing engagement in activity, discussion with the residents at residents' meetings and as part of the formal six-monthly care plan review.</p> <p>The planned activity programme sighted reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular outings or events are offered. The programme aims to include physical, social, intellectual and personalised activities. Examples included chair exercise classes, walking groups, news reading, balloon tennis, arts and crafts, and outings. There are some residents who choose not to participate but prefer to engage in personal activities of their choice and jigsaws, library books and other solo activities are available.</p> <p>Smaller lounges are available for residents who prefer quiet areas and whānau rooms are available for family visits. There are multiple small garden areas available for residents' use, including a secure garden attached to the dementia unit.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. The programme includes activity planning 24 hours a day with carers offering activities when the diversional therapy team is not present. Carers in the secure dementia unit were observed playing memory games and balls games with the residents in addition to the activities offered by the diversional therapy team.</p> <p>The younger residents with a physical disability have a lifestyle activity plan completed which identifies strategies to maintain connections with the community. This was verified through observation, interview, and file reviews.</p>

		<p>The activities programme is displayed for the residents and family. Resident participation in the activities programme is voluntary.</p> <p>Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the registered nurse, and if appropriate to the GP.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wound care with photographs taken to document progress. When necessary, and for unresolved problems, long term care plans are added to and updated. Carers interviewed stated they are kept up to date when a resident's needs change and the GP was happy that nurses identify when a resident is deteriorating and contact him promptly.</p> <p>Case conference reviews involving the family occur and evidence of residents and families/whānau involvement in the evaluation of progress and any resulting changes was seen in files reviewed.</p>
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>A current building warrant of fitness (expiry date 1 May 2022) was publicly displayed.</p> <p>There have been no changes to the building since the previous audit which required a building consent. The nurses' station upgrade is being undertaken within the existing building footprint.</p> <p>A previous corrective action in relation to the testing and tagging of electrical equipment, calibration of bio medical equipment and room fridge monitoring has been fully addressed, with comprehensive records and a reliable system for implementing and recording testing results. Sampling of a variety of equipment and records confirmed this is now effectively implemented by the trained on-site maintenance staff member, who also arranges an external contractor to undertake testing of the biomedical equipment. A sample of refrigerators indicates a suitable system for managing food disposal and fridge temperatures has been implemented.</p>
Standard 3.5: Surveillance Surveillance for infection is carried out in	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, fungal, eye, oral, gastro-intestinal, the upper and lower respiratory tract and wounds. The clinical manager reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and at weekly clinical meeting

<p>accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>to review progress. Families are kept informed and communication with families was seen in files reviewed. Monthly surveillance data is collated by the clinical manager and reviewed to identify possible causative factors and required actions. Collated data is forwarded to the Oceania regional office for benchmarking with other facilities in the Oceania group. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility IPC meeting, the regional clinical manager cluster meeting and the Oceania clinical governance meeting.</p> <p>Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. A summary report for a recent respiratory infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p> <p>Covid-19 information is available to all visitors to the facility. Oceania information including MoH information was available on site. There are adequate IPC resources available should a resident infection or outbreak occur. Residents have been provided with information and education through the monthly residents' meetings.</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 (HDSS 8134:2008) and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is a registered nurse who has undertaken additional training in restraint minimisation. She provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, there were no residents using restraints and five residents were using at least one enabler, which were the least restrictive and used voluntarily at their requests. A similar process is followed for the use of enablers as is used for restraints and is included in the plan of care.</p> <p>Restraint is used as a last resort when all alternatives have been explored. There has been no restraint use since mid-2021 as evidenced on review of the restraint register, the quality and staff meeting minutes, files reviewed, and from interviews with staff.</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)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	Complaint responses are managed in accordance with Code of Health and Disability Services Consumers' Rights timeframes up to the point of closure. The organisation is commencing transition of concerns and complaints records to an electronic system; however, in the hardcopy samples reviewed for 2021 (seven), there is no indication on the forms or letters that the complaint has been resolved or closed.	Close out of complaints was not recorded in the sample of seven complaints reviewed.	Ensure records of complaints include the complainant's response to the outcome and close out date. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.