Oceania Care Company Limited - Te Mana Home & Hospital

Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Oceania Care Company Limited
Premises audited:	Te Mana Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 27 April 2017 End date: 28 April 2017

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: 43

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

Te Mana Home and Hospital (Oceania Healthcare Limited) can provide care for up to 46 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. Occupancy on the day of the audit was 43. The service provides rest home, hospital and young persons with physical disability care.

The audit process included the review of policies and procedures, the review of residents and staff files, and observations and interviews with residents, family, management, staff and a general practitioner.

The business and care manager is responsible for the overall management of the facility and is supported by the regional and executive management team. Service delivery is monitored.

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.

Residents receive services in a manner that considers their dignity, privacy and independence. The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights information (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, are accessible. This information is given to residents and their families on admission to the facility. Residents and family interviews confirmed their rights are met. Interviews confirmed that staff are respectful of the residents' needs and communication is appropriate.

The business and care manager is responsible for the management of complaints. Residents and families interviewed confirmed they are informed of the process to make a complaint.

Staff confirmed an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents.

The residents' cultural and spiritual needs, and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices in relation to the care they receive.

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 for Te Mana Home and Hospital and is responsible for the services provided. The business and care manager is qualified for the role.

Oceania Healthcare Limited has a documented quality and risk management system that supports the business management and provision of clinical care. Quality and risk performance is reported through meetings at the facility and is monitored by the organisation's management team through the business status reports and regional operations manager reports.

Quality improvement is monitored and bench marking reports include incident/accidents, infection, complaints and clinical indicators with trends analysed to improve service delivery. Incidents and accidents are investigated using a root cause analysis methodology and open disclosure to patients and their families is practised. The organisation has systems in place to manage and predict staffing levels. Human resource policies and processes are aligned with good employment practice and legislation. Orientation, ongoing learning and development opportunities are available for staff. Resident information is identifiable, accurately recorded, current, confidential, accessible when required and securely stored.

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.

The initial assessments, initial care plans, short-term care plans for acute conditions and long-term care plans for long-term service delivery are completed within the required timeframes. Care plan evaluations are documented, resident-focused and indicate progress towards meeting the residents' desired outcomes.

Where the progress of a resident is different from expected, a short-term care plan is completed for short-term problems. The residents and the family members have an opportunity to contribute to assessments, care plans and evaluation of care.

The planned activities are appropriate to the group setting and younger residents have additional activities to address their social needs. The residents and families interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. There were no residents self-administering medicines.

The menu has been reviewed by a registered dietitian and meets nutritional guidelines for older people. The residents' special dietary requirements and needs are met. Residents have choices and can make input into menu changes.

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.

Te Mana Home and Hospital have systems to ensure the environment for patients, staff and visitors is clean and safe. There is a cleaning schedule and cleaning staff are trained. Waste is segregated and disposed of according to policy and legislative requirements. Staff are educated to handle waste safely. Hazardous substances and chemicals are stored and registered appropriately.

The facility has a current building warrant of fitness and a preventative maintenance programme to ensure the building, utilities and equipment comply with the regulations and safety requirements. Residents' rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Oceania Healthcare Limited has developed and maintained plans to respond to emergency situations, including fire and medical emergencies. Exercises for disaster response and evacuation of buildings are held and staff are trained. There is emergency equipment and supplies available on site in the event of an emergency. Laundry services are contracted out.

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 service uses Oceania Healthcare Limited policies and procedures for restraint minimisation and safe practice, meeting the requirements of the standard. There are systems in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The restraint coordinator confirmed that enabler use is voluntary.

There were nine residents using restraint and four residents using enablers on audit days.

The residents' files reviewed demonstrated that the service focuses on de-escalation processes, and restraint and enabler use is documented in residents' care plans.

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 policies and procedures include guidelines on prevention and minimisation of infection. New employees are provided with training in infection control practices and there is ongoing infection control education available for all staff.

The infection control surveillance data confirmed that the surveillance programme is appropriate for the size and complexity of the service. The surveillance of infections is occurring according to the infection control programme. The surveillance data is collated, analysed, benchmarked within the organisation and reported to their support office.

There has been no outbreaks since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Te Mana Home and Hospital is guided by Oceania Healthcare Limited's overarching policies, procedures and processes to meet its obligations in relation to the Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code). Staff interviewed demonstrated knowledge, understood the requirements of the Code and were observed demonstrating respectful communication, open disclosure, encouraging patient independence, providing options and maintaining residents' dignity and privacy. The Code is a component of the staff induction process and the education planner reviewed evidenced ongoing education on the Code is provided.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of care. Resident files identified informed consent is obtained. Interviews with staff confirmed their understanding of informed consent processes. Service information pack includes information regarding informed consent. The BCM and CL discuss informed consent processes with residents and their families during the admission process. The

		policy and procedure includes guidelines for consent for resuscitation/advance directives and resuscitation orders are completed for residents when applicable.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Resident information relating to advocacy services is available at the entrance to the facility and in information packs provided to residents and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Staff training regarding advocacy services was last provided in 2017. Family and residents confirmed that the service provides opportunities for the family/EPOA to be involved in decisions and they stated they had been informed about advocacy services. Residents are encouraged to have support people of their choice with them when information is being provided. Resident interviews confirmed that they were aware of advocates and how they could access an advocate or a support person. External support agencies visit to support residents and families, and provide education forums for staff.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy and residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families confirmed they could visit at any time and are always made to feel welcome. Residents are encouraged to be involved in community activities and to maintain family and friend networks. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisation's complaints policy and procedures is in line with the Code and include timeframes for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner. Staff, residents and family confirmed they knew the complaints process. The BCM is responsible for managing complaints. Residents and family stated complaints are dealt with as soon as they are identified. Residents and family members were able to describe their rights and advocacy services particularly in relation to the complaints process. There are two complaints lodged with the Health and Disability Commissioner since the previous

		audit waiting for closure. There have been no complaints with external agencies.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code is displayed at the entrance in poster form and pamphlets are readily available. Information about the Code is provided in all new residents' information packs. The Code is also available in te reo Māori and other languages. The business and care manager (BCM) and the clinical leader (CL) discuss the Code with residents and their family on admission. Discussion relating to the Code is also included on the agenda and discussed at the residents' meetings. The consumer auditor interviews with residents and family confirmed their rights are being upheld by the service. Information on the Code is provided to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. The posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has a philosophy that promotes dignity, respect and quality of life. The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to individualise their rooms. Spaces are available for private conversations and patient information was observed to be away from public view. The residents/family confirmed their physical privacy and their dignity is maintained. A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner, with strategies documented to manage any inappropriate behaviour if there are any issues for a resident. Health care assistants (HCA) were observed knocking on bedroom doors prior to entering, doors were closed when cares were been given. Residents and staff reported they had not witnessed any abuse and neglect, however, they understood the processes to follow in the event of this occurring. Staff receive annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports or on the incidents reviewed in residents' files. Staff interviewed were aware of the need to ensure residents are not exploited, neglected or abused. Staff can describe the process for escalating any issues. Staff are clear about professional boundaries and ethics that inform their behaviour when interacting with residents.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori	FA	The Māori health plan describes that the holistic view of Māori health is to be incorporated into the delivery of services. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. Access to Māori support and advocacy services is available, if required, from

		a local provider of health and social services. Cultural celebrations are included in the activities plan.
have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		Staff members also provide cultural advice and support for residents and staff, if required. A cultural assessment is completed as part of the care plan for all residents. Specific cultural needs are identified in the residents' care plans and this was sighted in files reviewed. Staff are aware of the importance of whānau in the delivery of care for the Māori residents. Whānau are able to be involved in the care of their family members.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service has appropriate policies and procedures to ensure the recognition of Māori values and beliefs and that of other cultures. Residents/family verified they were consulted on their individual ethnicity, culture, values and beliefs and staff respected these. Residents' personal preferences, required interventions and special needs were included in the care plans reviewed. Staff are educated as part of the mandatory education provided on cultural safety and cultural appropriateness. The Code of Rights is available in different languages and formats. Chaplaincy service is offered to residents and their families as needed or requested.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility implements the Oceania Healthcare Limited (Oceania) policies and procedures based on good practice, current legislation and guidelines. Staff confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. The service has clear expectations around staff conduct which is clearly communicated to staff during the employment process, orientation/induction and subsequent ongoing education (where relevant). Staff training includes discussion of the staff code of conduct and prevention of inappropriate care. The staff are aware of the need to ensure unbiased fair care and treatment is provided regardless of the age, gender, religion, sexual preferences, ethnicity and/or social standing. All allied medical and other health professionals also abide by the regulatory bodies to which they belong. There were no complaints recorded in the complaints register for the previous 12 months relating any form of discrimination. Job descriptions include the responsibilities of position, including ethical issues relevant to the role. Staff orientation and induction includes recognition of discrimination, abuse and neglect. Staff confirmed their understanding of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an	FA	The service implements Oceania policies to guide practice. The policies align with the Health and Disability Services Standards.

| | | The organisation's quality framework includes their internal audit programme. Benchmarking occurs across all the Oceania facilities. There is an internal mandatory training programme for all staff and managers are encouraged to complete management training. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice and evidence-based practice.

The consumer auditor interviews with residents and families expressed a high level of satisfaction with the care delivered. |
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| appropriate standard. | | |
| Standard 1.1.9: Communication

Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The consumer auditor interviews with residents, representatives and/or family members confirmed they are kept informed about any changes to their own/the resident's health status, and are notified in a timely manner of the results of any investigations and/or treatment outcomes. This was supported in the residents records reviewed. There was evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services are accessible to staff for residents. Staff demonstrated an understanding of how to access interpreter services as required. |
| Standard 1.2.1: Governance

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Te Mana Home and Hospital can provide services for up to 46 residents. The service provides care for hospital, rest home care and residents with physical disability. Of the 46 residents, there were 23 hospital care, 7 rest home and 13 classified under the young person's disabilities contract.

The facility is part of the Oceania Healthcare Limited (Oceania) with the executive management team providing support to the service. Communication between the service and managers occur monthly with the clinical and quality manager providing support during the audit. The monthly business status report provides the executive management with progress against identified indicators.

The organisation's mission statement and philosophy are displayed at the entrance to the facility. This information is included in the booklets given to new residents and staff training is provided annually.

The service has a business and care manager (BCM) supported by a clinical leader (CL). The BCM has been in the role for one year. The BCM is a registered nurse (RN) and has a management background with aged residential care. The CL has been working in the facility as a RN for five years and has been in the CL role for one year. The BCM and the CL hold current annual practising certificates and are supported by the clinical and quality manager (CQM). The management team is well supported in their roles and have completed appropriate induction and orientation to their roles. HealthCERT was informed of the appointment of the CL. |

| Standard 1.2.2: Service Management

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the business and care manger, the clinical leader is in charge with support from the regional operations manager and clinical and quality manager (organisational).
Standard 1.2.3: Quality And Risk Management Systems

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Te Mana Home and Hospital uses the Oceania quality and risk management framework to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Oceania support office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hardcopy. New and revised policies are presented to staff to sign to evidence they have read and understood the new/revised policy.

Service delivery is monitored through review of: incidents and accidents; complaints management; surveillance of infections; pressure injuries; soft tissue/wounds; and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues completed. Internal audits are completed in line with the quality audit schedule, with evidence of corrective actions identified and implemented.

Monthly staff meeting minutes, including quality improvement, health and safety and infection control, evidence communication with all staff around all aspects of quality improvement and risk management. Staff report that they are kept informed of quality improvements. There are monthly resident meetings coordinated by the diversional therapist that keep residents informed of any changes. Family are invited to come to the resident meetings.

The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly with a facility health check completed quarterly by the CQM.

Survey for family and residents was completed in 2017 and positively reflects the satisfaction of the residents and family. |

| Standard 1.2.4: Adverse Event Reporting

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The BCM is aware of situations in which the service is required to report and notify statutory authorities.

Staff interviews and review of documentation confirmed that staff document adverse, unplanned or untoward events on an accident/incident form which are signed off by the BCM. There have been no deaths referred to the coroner and district health board (DHB) since the last audit. A stage five pressure injury was reported to HealthCERT. |
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| Standard 1.2.7: Human Resource Management

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | All staff complete an orientation programme and health care assistants are paired with a senior health care assistant until they demonstrate competency on a number of tasks including personal cares. Health care assistants confirmed their role in supporting new staff. A new staff member interviewed confirmed they had a comprehensive orientation programme.

The registered nurses hold current annual practising certificates along with other health practitioners in the service. Staff files include appointment documentation including: signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal.

Annual competencies are completed by clinical staff and evidence of completion of competencies is kept on staff files. The organisation has a mandatory education and training programme with an annual training schedule documented. Staff attendances are documented for internal training provided with registered nurses and health care assistants attending.

Education and training hours are at least eight hours a year for each staff member. One registered nurse has interRAI training and one registered nurse is in the process to complete training. Staff have completed training around pressure injuries in 2017. |
| Standard 1.2.8: Service Provider Availability

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.

There are 48 staff, including the management team, clinical staff, a diversional therapist and household staff. There is always a registered nurse on each shift. The BCM and CL are on call after hours. Residents and families confirmed staffing is adequate to meet the residents' needs. |

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' ongoing care history and activities. Resident files are in use that are appropriate to the service. There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner. Entries are legible, dated and signed by the relevant health care assistant, registered nurse or other staff member, including designation. Resident files are protected from unauthorised access by being locked away in an office. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This includes medical care interventions. An electronic medication management system is in place.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents' entry processes into the service are recorded and implemented. Needs assessments are completed for rest home and hospital level of care, including physical disabilities. The organisational information pack is available for residents and their family. The admission agreement defines the scope of the service, includes all contractual requirements and evidenced resident and/or family sign off. Interviews with residents and family and review of records confirmed the admission process was completed by staff in a timely manner.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and coordinated manner. There is open communication between services, the resident and the family. At the time of transition appropriate information is supplied to the service or individual responsible for the ongoing management of the resident. Referrals are documented in the residents' progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that	FA	The medication areas evidence an appropriate and secure medicine dispensing system. The medicines storage area is free from heat, moisture and light, with medicines stored in original dispensed packs. Weekly checks are in place. There is evidence of six monthly physical stocktakes by the pharmacy. The medication fridge temperatures are conducted and recorded.

complies with current legislative requirements and safe practice guidelines.		All staff authorised to administer medicines have current competencies and education in medicine management is provided. Electronic medicine charts evidenced current residents' photo identification, legibility, as required (PRN) medication is identified for individual residents and correctly prescribed, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GP. Residents' medicine charts record all medications.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Dietary assessments are undertaken for each resident on admission and a dietary profile developed. Personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook. Special equipment, to meet resident's nutritional needs, was sighted. Residents' files demonstrated monthly monitoring of individual resident's weight. Residents stated they were satisfied with the food service. Residents who are identified with weight loss have completed short-term care plans and relevant interventions to monitor the weight loss. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and confirmed in the resident meeting minutes. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal, complies with current legislation and guidelines.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is a process in place to inform residents and family of the reasons why services had been declined, should this occur. When residents are declined access to the service; residents and their family, the referral agency and/or the GP are informed of the decline to entry. The residents would be declined entry if not within the scope of the service or if a bed was not available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents' needs, outcomes and goals are identified through the assessment process. Assessments are recorded, reflecting data from a range of sources, including the resident; family; GP; specialist and the referrer. Policies and protocols are in place to ensure continuity of service delivery. The service has appropriate resources and equipment. The assessments are conducted in a safe and appropriate environment, usually the resident's room. Interviews with residents and family confirmed their involvement in the assessments, care planning, review, treatment and evaluation of care.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Residents' care plans are individualised, integrated and up to date. Recorded interventions reflect the risk assessments and the level of care required. InterRAI assessments are completed by RNs and inform the person centred care plans. The short-term care plans are developed for the management of acute problems, when required, and signed off by the RN when problems are resolved. Interviews with residents confirmed they have input into their care planning and review.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The residents' care plans evidence interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records are current. Interviews with residents and families confirmed their and their relatives' care and treatments meet their needs. Staff interviews confirmed they are familiar with the needs of the residents they are allocated to. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Interviews with the diversional therapist (DT) confirmed the activities programmes meet the needs of the service groups. The DT plans, implements and evaluates the activities programmes. There is one activities programme for the rest home and hospital residents and all younger people with disabilities have specific activities added to their activities programmes to facilitate more social interaction with others. Regular exercises and outings are provided for those residents able to participate. The activity programmes include input from external agencies and supports participation in ordinary unplanned/spontaneous activities, including festive occasions and celebrations. There are current, individualised activities care plans in residents' files. The residents' activities attendance records are maintained. The residents' meeting minutes evidenced residents' involvement into the planned activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. Change is noted and reported to the RN. Care plan evaluations and reassessments occur every six months or when the resident's condition changes. Short-term care plans are initiated for short-term concerns, such as: infections; wound care; changes in mobility and other short term conditions. Short-term care plans are reviewed daily, weekly or fortnightly, as indicated by the degree of risk noted during the assessment process. The wound care plans evidence timely reviews.

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service has processes in place to provide opportunities for residents to choose when accessing or when being referred to other health and/or disability services. The family communication sheets, located in the residents' files, confirmed family involvement. The service has a multidisciplinary team approach. Progress notes and communication records confirm residents and their families are advised of their options to access other health and disability services.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place and incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirements for labels to be clear, accessible to read and free from damage. Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education in safe and appropriate handling of waste and hazardous substances. There is provision and availability of protective clothing and equipment appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles; gloves; aprons; footwear, and masks. Clothing is provided and used by staff. During a tour of the facility protective clothing and equipment was observed in all high risk areas. Chemicals are labelled throughout the facility. There are sharps bins utilised. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are stored in a designated shed with chemical hazard signs.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed. There have been no building modifications since the last audit, although there has been refurbishment of the facility as part of the Oceania's facilities upgrade programme. There is a planned and reactive maintenance schedule implemented. The service has an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually. Interviews with staff and observation of the facility confirmed there is adequate equipment. There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are internal courtyard areas with shade and outdoor furniture. There is a veranda/walkway enabling residents with the ability to walk around the facility

		under cover.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible toilets/bathing facilities. All toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence. Auditors observed residents being supported to access communal toilets and showers, in ways which were respectful and dignified.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Equipment was sighted in rooms requiring this with sufficient space for the equipment, staff and the resident. Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make their suite their own. Residents spoke positively about their rooms. There are designated areas to store mobility aids, hoists and wheelchairs. The hospital rooms and assisted care rooms are large enough to accommodate specific aids.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The service has lounge/dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The dining areas have ample space for residents. Residents can choose to have their meals in their room.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry	FA	Laundry is completed off site and is delivered daily. Laundry is transported in appropriate colour coordinated linen bags. Laundry staff sort the personal laundry in the evening and health care assistants are required to return linen to the rooms. Residents and family members confirmed that the laundry is well managed. There are cleaners on site seven days a week. The cleaners were observed to have the trolley in the room with them when cleaning and all had appropriately labelled containers

services appropriate to the setting in which the service is being provided.		on the trolleys. Cleaning is monitored through the internal audit process.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The fire evacuation plan is approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. A fire drill is conducted six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. Fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes. There is always one RN with a current first aid certificate on duty. A disaster management plan is in place with clear information for staff to follow in the event of an emergency. There are adequate emergency supplies, including food, water, blankets, emergency lighting and a gas barbeque. An electronic call bell system is in place. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways and dining rooms. Call bell audits are routinely completed. Observation on the days of audit and interviews with residents and families confirmed there are prompt responses to call bells. Sensor mats are used where appropriate.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature. Families and residents confirmed that rooms are maintained at an appropriate temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The Oceania infection prevention and control policies and procedures manual provides information and resources to inform staff on infection prevention and control. Strategies are in place to prevent exposure of infections to others. The responsibility for infection control is clearly defined in the infection prevention and control policy, including the responsibilities of the Oceania infection control committee (company-wide); infection control nurse and the infection control team. There is a signed infection control nurse job description outlining responsibilities of the position. The infection control nurse is supported in their role by the business and care manager, the clinical and quality manager, the clinical manager and the infection control team. The infection control nurse is a registered nurse.

Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control nurse has access to relevant and current information, appropriate to the size and complexity of this service. Infection control is an agenda item at the facility's staff meetings, evidenced during review of meeting minutes and interviews with staff. The internal audit programme includes infection control audits to monitor the implementation of the infection control programme.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. Policies are accessible to all personnel. The infection control policies and procedures are developed and reviewed regularly in consultation and input from relevant staff and external specialists. Infection control policies and procedures identify links to other documentation in the facility.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control education is provided to all staff. Infection control forms part staff orientation and education occurs as part of the ongoing in-service education programme. Interviews with staff advised that clinical staff identify situations where infection control education is required for a resident, including hand hygiene and cough etiquette. A registered nurse completed additional training for the role as the infection control nurse. The infection control staff education is provided by the ICN, RNs and external specialists. Education sessions have evidence of staff attendance/participation and content of the presentations. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews.
Standard 3.5: Surveillance	FA	The infection control nurse is responsible for the surveillance programme. Monthly surveillance

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		analysis is completed and reported at staff facility's meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained. Residents' files evidenced the residents' who were diagnosed with an infection had a short-term care plan in place. In interviews, staff reported they are made aware of any infections through verbal handovers; short-term care plans and progress notes and communication with RNs and the clinical leader. There have been no outbreaks since the previous audit. The facility's surveillance data is benchmarked against other Oceania facilities and this information is shared with staff and management.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint and enabler definitions in the Oceania company-wide policy are congruent with the definitions in the standard. Assessment of residents, care planning, monitoring and evaluation of restraint and enabler use is recorded and implemented. There were nine residents at the facility using restraints and four using enablers on audit days. The restraint and enabler use was documented in residents' care plans. Enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety confirmed by residents, family and staff. Enabler usage and prevention and/or de-escalation education and training is provided. Staff records evidenced restraint minimisation and safe practice training. Analysis of restraint data is conducted monthly by the clinical and quality manager.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	Legislation and requirements for restraint, inclusive of definitions and safe and appropriate guidelines for management of the use of restraint, is documented. The processes implemented reflect safe use of restraint. Restraint approval is completed with the RN, the GP and the restraint coordinator. Restraint assessment authorisation and plans are completed by the RN. The requirements for the use of the restraint are explained to the resident/family/whānau. Evaluation is undertaken to measure the effectiveness of restraint use and completed three monthly. The resident/family/whānau are involved in the evaluation process. Staff confirm their understanding and use of the restraint. The person centred care plans identify restraint goals, interventions and outcomes. Education is provided to all staff in the form of workshops and covers alternatives to restraint use as well as the management processes for restraint minimisation and safe practice.

Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service records culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. Restraint risks and monitoring timeframes are identified in the restraint assessment records.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint coordinator utilises other means to minimise risk, for example, the use of sensor mats prior to implementation of restraint. Restraint consents are signed by the GP, family and the restraint coordinator. The GP confirmed that the facility uses restraint safely.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint is still required. The family are involved in the evaluation of the restraints' effectiveness and reviews. Documentation was sighted in the progress notes regarding restraint related matters. Restraint minimisation and safe practices are reviewed by the restraint committee at three monthly intervals.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Three monthly monitoring and annual quality reviews are conducted relating to the use of restraint/enablers. Restraint committee meetings are held monthly. Senior staff and registered nurses attend. The restraint coordinator reports to management and to support office on a monthly basis. Quality review findings and any recommendations are used to improve service provision and resident safety. The restraint minimisation policies are current and are available to guide staff. Restraint minimisation and safe practice education is provided for all staff.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.