Oceania Care Company Limited - Wharerangi

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:	Wharerangi
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 18 September 2017 End date: 19 September 2017

Proposed changes to current services (if any): The reduction of three dementia unit beds, from 13 to 10, by moving the dementia unit doors back to their original site. This increases the dual-purpose beds from 34 to 37 with the total bed numbers remaining at 47.

Total beds occupied across all premises included in the audit on the first day of the audit: 41

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

Wharerangi can provide rest home, dementia and hospital level care for up to 47 residents. The facility has applied to reduce dementia unit beds by three, from 13 to 10, by moving the dementia unit doors back to their original site and increasing dual purpose beds by three from 34 to 37, with the total bed numbers remaining at 47. The changes are fit for purpose.

This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

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

Oceania Healthcare Limited is responsible for the overall management of the facility. The business care and village manager is responsible for the facility and is supported by the clinical manager and acting regional operations manager. Service delivery is monitored.

There are no areas identified that require improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service, is available. This information is given to residents and their families on admission to the facility. Staff could demonstrate an understanding of residents' rights. The facility has a documented and implemented complaints management system.

Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Oceania Healthcare Limited is the governing body and is responsible for the services provided at this facility. A business plan and quality and risk management systems document the scope, direction, goals, values and mission statement of the facility.

The facility has an incident and accident management system that records and reports all adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting.

The quality and risk management system supports the provision of clinical care at the service. Systems are in place for monitoring adverse events and the quality of services provided. Quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status and clinical indicator reports. Corrective action plans are documented with evidence of resolution of identified issues.

The service is managed by a business, care and village manager who is supported in their role by a clinical manager. The clinical manager is responsible for the oversight of the clinical service provision in the facility. Human resource policies are current and implemented. Registered nurses are on duty 24 hours a day and are supported by adequate levels of care and allied health staff. On-call arrangements for support from senior staff are in place.

Resident information is recorded accurately and documented in a timely manner. All resident information is maintained in a secure environment, with no public access.

Continuum of service delivery

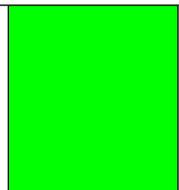|		
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

The clinical team ensures that 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 the management of the short-term problems. The residents and their family members have opportunity to contribute to assessments, care plans and the evaluation of their care.

Planned activities are appropriate to the group setting and residents in the dementia unit have planned activities over a period of 24 hours to guide staff in the management of challenging behaviour. 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, including an electronic process for the administration of medicines. 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 from the Oceania Healthcare Limited support office, 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. |

A current building warrant of fitness is displayed. All building and plant complies with legislation. A preventative and reactive maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Fixtures, fittings, and floor and wall surfaces are made of accepted materials for this environment. The physical environment reduces risks and promotes safety and independence for residents. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Residents are provided with accessible and safe external areas with shade.

The service has cleaning and laundry processes in place. The service is fit for the purpose, including the external environment.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

Restraint minimisation and safe practice

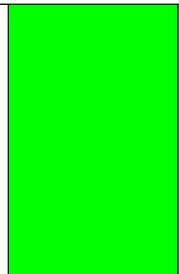| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

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, when being used. There were two residents using restraint and no residents using enablers on audit days.

The residents' files reviewed demonstrated that the service focuses on de-escalation processes, and restraint and enablers, when in use, are documented in residents' care plans. Staff in the dementia unit confirmed understanding on how to use the activities wheel for the management challenging behaviour over 24 hours and that the main focus is on de-escalation and prevention of such behaviour.

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 the Oceania Healthcare Limited support office.

There have 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	Staff receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) as a requirement of their orientation to the service and through the annual education and competencies programme. Staff interviews confirmed their understanding of the code. Evidence that the Code is implemented in everyday practice includes maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs. The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information. The Code is also available on posters which are visible in all resident and family areas of the facility. Education relating to the Code and complaints is provided. The Health and Disability Commissioner advocate visits two-monthly, through the accredited visitor programme, to talk to residents. Interviews and observation confirmed that staff are respectful towards residents and family members.
Standard 1.1.10: Informed Consent	FA	The service information pack includes information regarding informed consent. The registered

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.		nurse discusses informed consent processes with residents and their families/whānau during the admission process. Staff confirmed their understanding of informed consent processes. The informed consent policy and procedure directs staff in relation to gaining informed consent. This included guidelines for consent for resuscitation/advance directives. Staff ensure that all residents are aware of treatment and interventions planned for them, and that the resident and/or significant others are included in the planning of that care. All resident files identify that the required consents are collected. The GP signs to state competence of the resident and the resuscitation status is ticked on the resident files reviewed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the Health and Disability Commissioner's Office is provided to residents and families. Information on advocacy services is available at the entrance to the service. Staff training on the role of advocacy services is included in training on the Code with this provided to staff as part of the annual study day. Discussions with family and residents identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files included information on residents' family/whānau, chosen social networks and community links.
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	There are no set visiting hours and family reported that they are welcome to visit at any time. Residents confirmed they are supported and encouraged to access community services with visitors or as part of the planned activities programme. The service also encourages the community to be a part of the residents' lives with visits from entertainers and community groups and this was observed to occur at audit.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service's complaints policy and procedures are 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 was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. The complaints policy and form is included in the information pack given to residents

		on admission. Residents and family members stated they would feel comfortable complaining.
		There have been no complaints lodged with the Health and Disability Commission or other external authorities since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and information on the advocacy service is available and displayed in English and te reo Māori in the foyer and other areas in the facility. The admission information packs reviewed included information on the Code, advocacy and complaints processes. Interviews confirmed explanations regarding their rights occurred on admission. The business, care and village manager (BCVM), clinical manager (CM) and registered nurses (RNs) follow up with a discussion with residents and families during the admission process. Residents and family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service on admission. Resident and family interviews and the completed resident and family surveys indicated residents are aware of their rights and are satisfied with this aspect of service delivery. Residents and family interviewed received copies of the Oceania handbook. Families and residents are informed of the range of services. This is included in the service agreement and admission agreements. Residents interviewed confirmed they had access to an advocate if needed.
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 facility has policies and procedures that are aligned with the requirements of the Privacy Act and Health and Information Privacy Code. Initial and ongoing assessments to ascertain details of people's beliefs and values are completed with the resident and family members. Interventions to support these are identified and evaluated. Residents and family confirmed that they are included in the care planning process and are addressed by their preferred name. Healthcare assistants (HCAs) were observed to support the residents' independence by encouraging them to be as active as possible. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and not in public areas; there are areas in the facility which can be used for private meetings. Residents and family interviews confirmed that personal privacy and dignity is maintained and staff treated them with respect. Healthcare assistants were observed to knock on bedroom doors prior to

		entering rooms. Residents and families confirmed that their privacy is respected.
		Staff have had education around abuse and neglect and are able to describe the reporting process should any be identified. Family, staff, residents and the general practitioner (GP) stated that there is no evidence of abuse and neglect.
		Residents are supported to access spiritual support when needed and there are church services at least weekly.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service implements the Māori health plan policy and cultural competency policies to eliminate cultural barriers. The rights of the residents/whānau to practise their own beliefs are acknowledged and guidelines for relationships with those who identify as Māori and education for staff are included in the Māori health plan. The activities coordinator completes the cultural assessments on admission and updates six monthly. Access to Māori cultural support and advocacy services is available, including through a Māori rātana minister who visits the facility at least weekly. There were four residents who identified as Māori during on-site audit. Interviews with residents and family confirmed their cultural needs are being met. Cultural training for staff has been provided.
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	There is a culturally competent services policy provides guidelines to staff to ensure cultural competency of staff during service delivery to residents and their families. Residents and family are involved in the assessment and the care planning processes. This was confirmed in interviews with residents and families. Information gathered during assessment includes the residents' cultural values and beliefs. Staff and resident/family interviews confirmed the service takes care to ensure that the cultural needs of residents are identified and met. Documentation provided evidence that cultural assessments were completed for residents and appropriate culturally safe practices are implemented and maintained, including respect for residents' cultural and spiritual values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The abuse and neglect policy provides guidelines for the management of risk to residents and staff that may arise from abuse or neglect. It includes definitions of abuse and neglect, education of staff, emergency and non-emergency actions, and associated and reference documents.

		Staff files have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. Families and residents expressed no concerns with breaches in professional boundaries, discrimination or harassment.
		Staff orientation and their employee agreement include standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the HCA's role and responsibilities.
		There is staff education in abuse and neglect.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	A staff education programme is implemented and staff can describe sound practice based on policies and procedures, care plans and information given to them via the RNs and GP. Consultation is also available with health professionals and specialists in the region with staff able to describe how and when they can make contact. Residents and families interviewed expressed a high level of satisfaction with the care delivered.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The accident/incident policy, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family members confirmed they are informed if the resident has an incident/accident, or has a change in health or needs. Family contact is recorded in residents' files. There are alternate monthly resident and family meetings. The meetings include information and updates related to the facility (e.g. staff changes, meals/menus, laundry and activities). Interpreter services, although not required for some years, are available through the Citizen's Advice Bureau Taupo. Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated,	FA	The Oceania Healthcare Limited's vision, values, mission statement and philosophy are displayed at the entrance to the facility. The organisation has systems in place recording the scope, direction and goals of the organisation. The business, care and village manager (BCVM) provides monthly status reports to the Oceania support office. These reports include

		quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes and clinical indicators.
and appropriate to the needs of consumers.		The BCVM is supported by the clinical manager (CM). The CM's appointment is full time and is responsible for all clinical matters. The CM has worked for the organisation for seven years. The BCVM has worked in the organisation for nine years and has been in the role three years. The BCVM has a certificate in business management.
		The facility can provide care for 47 residents requiring rest home, dementia care or age-related hospital level of care. Occupancy during the onsite audit was 41 residents. On the day of audit there were 22 rest home residents, 8 dementia care residents and 11 residents requiring hospital level care. The facility does not hold any additional contracts.
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	There are appropriate systems in place to ensure the day-to-day operation of the service continues should the BCVM be absent. The CM assumes the role and is supported by the clinical team leaders and the support office.
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	Wharerangi uses the Oceania Healthcare Limited (Oceania) quality and risk management framework that is documented 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. The support office reviews all policies, with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. Staff are notified of any new or revised policies and sign a form indicating that they have read and understood policies. All clinical staff interviewed reported they are kept informed of quality improvements. There are monthly staff, RN and infection control meetings held, that include health and safety and all aspects of the quality programme. The resident and family meetings include information and updates related to the quality and risk such as health and safety. Service delivery is monitored through review of complaints, review of incidents and accidents with monthly analysis of data, surveillance of infections, and implementation of an internal audit programme. Corrective action plans are documented and evidence of resolution of

		issues are documented when these are identified.
		Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. External contractors are monitored and comply with health and safety requirements.
		Resident/family satisfaction surveys are completed six monthly. Results documented from the recent survey indicate that residents and family are very happy with the service and environment with minimal suggestions for improvement. This was confirmed by resident and family interviews.
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 | Staff document adverse, unplanned or untoward events on an accident/incident form. Families are informed after adverse events. This was confirmed in clinical records and during family and resident interviews. Accident and incident forms are reviewed and signed off by the BCVM. Corrective action plans address areas requiring improvement and are documented. There is an open disclosure policy.

Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Policy and procedures meet the terms of essential notification reporting for example health and safety, human resources and infection control.

Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events notifications and their responsibilities relating to essential notification.

There have been no investigations or essential notifications since the last audit. |
| 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 | Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and authority. These are reviewed on staff files along with employment agreements, reference checking, criminal vetting, pre-employ drug testing, completed orientations and competency assessments.

Copies of annual practising certificates are reviewed for all staff and allied health professionals and contractors that require them to practice and are current. The clinical manager is responsible for the in-service education programme. Competency assessments such as |

		medication are completed and competencies were reviewed. Staff are supported to complete education delivered via the Oceania support office. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.
		An orientation/induction programme is available. The BCVM advised that staff complete orientation and induction at employment and personnel files reviewed verified that this is completed and documented for all new staff. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed an orientation, including competency assessments.
		The service has five registered nurses who have completed InterRAI training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. There is RN cover 24 hours a day. On call after hours registered nurse support and advice is provided by the CM and the BCVM for non-clinical support. Care staff interviewed reported adequate staff is available and that they are able to get complete their work load each day. Residents and family interviewed stated staff provide them with adequate care and there were no reported waiting times.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents' information is stored securely in staff areas. Clinical notes are current and accessible to all clinical staff; information containing sensitive resident information is not displayed in a way that it could be viewed by other residents or members of the public. Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including designation. Approved abbreviations are listed. Records are maintained of archived resident files. The service retains relevant and appropriate information to identify and track resident's records. There is sufficient detail in resident's files to identify each resident's ongoing care, history and activities. Documentation in individual resident files demonstrated service integration. The resident's national health index number, name, date of birth and general practitioner are used as the unique identifier. Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information.

		Resident and family interviews identified that they were confident that information of a sensitive or nature would remain confidential.
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, hospital and dementia level of care within the required timeframes. 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	Resident's exit, discharge or transfer is managed in a planned and coordinated manner. There is open communication between services, the resident and the family. 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 complies with current legislative requirements and safe practice guidelines.	FA	Medicines management evidenced appropriate and secure medicine dispensing systems. The medicines storage area is free from heat, moisture and light, with medicines stored in original dispensed packs. Weekly checks are completed. There was evidence of six monthly physical stocktakes by the pharmacy. The medication fridge temperatures are conducted and recorded. 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 completed and discontinued medicines are dated and signed by the GP. Interview with the GP confirmed effective communication and appropriate care. This service does not store vaccines. 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. Interview with the kitchen manager confirmed fridge/freezer temperature checks are completed three times per day with food temperature checks completed prior to and during serving of meals. All kitchen staff have completed food safety training. The kitchen manager (a trained chef) has been in the role for six weeks. 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	The service has 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. 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, including interRAI assessments. Assessments were 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 of residents. 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 notes 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 activities coordinator (AC) confirmed working 40 hours per week and being responsible for the activities programmes and meeting the needs of the service groups. The AC plans, implements and evaluates the recreational plans and programmes. The AC has one more unit standard to complete to qualify as a diversional therapist. There is an activities programme for the rest home and hospital residents and a programme specific to the needs of the residents in the dementia unit. 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 each residents' file and residents in the dementia unit have activities identified over 24 hours, for the management of challenging behaviour. The AC has the activity programmes reviewed by another Oceania facility's diversional therapist for appropriateness. The residents' activities attendance records are maintained. The residents' meeting minutes evidenced residents' involvement in the planned activities programme. Interviews with residents confirmed that they enjoy activities. Family interviews confirmed that activities are provided and that residents participate. During the audit days a variety of

		activities were observed.
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 RNs. 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 show 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	There are 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. There is a multidisciplinary team approach to the care of residents. 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 the hazard register is current. Policies and procedures for chemicals specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Current material safety data sheets are available throughout the facility and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Interviews with the household staff confirmed this. There is provision and availability of personal protective clothing and equipment including goggles/visors; gloves; aprons; footwear; and masks. During a tour of the facility, personal protective clothing and equipment was observed in areas where there are risks.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical	FA	A current building warrant of fitness is displayed. The service has a planned maintenance schedule implemented with a test and tag programme. Checking and calibration of clinical equipment is completed annually.

environment and facilities that are fit for their purpose.		The service upgraded and refurbished the rooms typically when they were vacated. All residents' rooms evidenced managed maintenance. There have been no building modifications since the last audit. The relocation of doors to re-designate three dementia beds as dual purpose, ensures the dementia unit remains secure and enables the re-designation of the dual beds to be fit for purpose.
		Interviews with staff and observation of the facility confirmed there is adequate equipment, including pressure relieving mattresses; shower chairs; hoists and sensor alarm mats.
		There are quiet areas throughout the facility for residents and visitors to meet providing privacy when required. There is an outside area with shade, seating and outdoor tables. There are ramps and rails at entrance doors for access for residents with disabilities.
		There is sufficient visitor parking space.
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. Visitors' toilets and residents' toilets are located close to communal areas. All the toilets have a system that indicates if it is engaged or vacant.
		All the residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence.
		Residents and family members report that there are sufficient toilets and showers. Auditors observed residents being supported to access communal toilets and showers in ways that are 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 in all the bedrooms to allow residents and staff to safely move around in the room. Equipment was sighted in hospital rooms where required, with sufficient space for both the equipment and at least two staff and the resident, for example, hoists and wheel chairs.
		The residents' rooms are personalised with their own furnishings, photos and other personal possessions of choice. Residents and families are encouraged to make the room their own.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining	FA	The service has lounges and dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access their own room or other areas for privacy, when required. Furniture is appropriate to the setting and arranged

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		in a manner which enabled residents to mobilise freely. There is furniture and shade in the garden areas.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Cleaning and laundry policies and procedures are documented and implemented. The facility has a designated cleaner who works five days per week. The cleaner could describe the cleaning processes in line with policy during interview. These were also observed by the auditor. There are safe and secure storage areas, and staff have appropriate and adequate access to these areas as required. Chemicals are labelled and stored safely within these areas. Sluice rooms are available for the disposal of soiled water/waste. Hand sanitizer and hand washing facilities are available throughout the facility. The facility has a designated laundry with correct demarcation and maintenance of clean and dirty areas. There are processes in place for the collection, laundering and storage of linen and residents' personal clothing. The effectiveness of the cleaning and laundry services is audited via the internal audit programme. There is a designated laundry staff member who works five weekdays per week and at interview the staff member was able describe correct procedures and practices in line with policy for managing clean and dirty laundry. Weekend laundry and cleaning duties is undertaken by a staff member. Residents and families stated they were satisfied with the cleanliness of the facility and there were no issues with regard to damaged or lost personal laundry. This was confirmed in satisfaction surveys. Residents and family have the opportunity to feedback on cleaning and laundry services at monthly facility meetings.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	An evacuation plan has been approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. Fire drills are completed six-monthly. The orientation programme includes fire and security training. Checking the fire exits for clearance is on the maintenance daily schedule. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency, including food; water; blankets; emergency lighting and gas barbeques. An electronic call bell system utilises a pager system. 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 and residents and family state that there are prompt responses to call bells. External doors leading to the gardens and outside doors are locked after sunset, these doors can only be opened from the inside. Staff complete a security check of all outside doors in the evening to confirm security measures are in place.
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, and an environment that is maintained at a safe and comfortable temperature. Monthly room temperature checks are monitored. There is a designated external smoking area. Family and residents stated that the building is maintained at an appropriate temperature all year round.
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 infection prevention and control policies and procedures manual provides information and resources to inform staff on infection prevention and control. The service has strategies 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 the clinical manager and is supported in their role by the business, care and village manager, the clinical and quality manager, the clinical manager and the infection control team. The infection control nurse is a registered nurse with current practicing certificate.
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	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.

needs of the organisation.		
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	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 staff. 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	Infection control education is provided to all staff. Infection control is included in staff orientation and education occurs as part of the ongoing in-service education programme. Interviews with staff confirmed that clinical staff identify situations where infection control education is required for a resident, including hand hygiene and cough etiquette. The infection control nurse has completed additional training; for example, the online infection prevention and safe practice training from the Ministry of Health, for the role as the infection control nurse. The infection control staff education is provided by the infection control nurse, 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 Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control nurse is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at staff facility's meetings. The auditor reviewed surveillance records over the previous six months. 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

		manager. 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 two residents at the facility using restraints and no enabler use on audit days. The restraint register reflects all restraints and previous enabler use. Restraints are recorded as part of the person centred care plans. Enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed by staff. Enabler usage and prevention and/or de-escalation education and training is provided when needed. 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	The legislative requirements for restraint, including definitions and safe and appropriate guidelines for management of the use of restraint, are documented. Implemented processes reflect safe use of restraint. Restraint approval is completed with the RNs, the GP and the restraint coordinator, who is also the clinical manager. Restraint assessment authorisation and plans are completed by the RNs. 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 this is completed three-monthly. The resident/family/whānau are involved in the evaluation process. Staff confirmed their understanding and use of the restraint. The person centred care plans identify restraint goals, interventions, outcomes, risks and monitoring timeframes. 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	FA	The service records culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. Restraint risks and monitoring timeframes are identified and adhered

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.		to. Restraint monitoring records reflect episodes of restraint, monitoring and episodes of respite. The restraint records for both residents using restraint were reviewed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint coordinator utilises other means to minimise risk, including, 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. The service uses a restraint register for recording sufficient information to provide an auditable documentation of restraint use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint coordinator evaluates all episodes of restraint. The 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	The service completes 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 monthly. Corrective actions 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.