Oceania Care Company Limited - Whitianga Continuing Care

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:	Whitianga Continuing Care
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 January 2019 End date: 30 January 2019

Proposed changes to current services (if any): 17 rest home level beds and 36 hospital level beds to be reconfigured to dual purpose beds. There will be one bedroom remaining as rest home only. There will be no change to the total number of beds.**Total beds occupied across all premises included in the audit on the first day of the audit:** 51

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

Whitianga Continuing Care is part of Oceania Healthcare Limited. The facility can provide services for up to 54 residents requiring rest home or hospital level of care. There were 51 residents at that facility on the first day of the audit.

This certification audit was conducted against the Health and Disability Service Standards and the facility's contract with the district health board. The audit process included the review of policies and procedures, review of resident and staff files, and observations and interviews with residents, family members, management, staff, and a general practitioner.

The audit process also included a review of the redesignation of 53 of the 54 bedrooms to dual purpose. Review confirmed bedrooms were suitable for dual purpose use.

There were no areas identified at this audit as requiring 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 Commissioners' Code of Health and Disability Consumers' Rights; the complaints process; and the Health and Disability Advocacy Service is made available to residents and their families on admission and is accessible to residents and their families in the facility.

Staff interviews demonstrated an understanding of residents' rights and obligations. Residents and family members confirmed their rights are being met; staff are respectful of their needs and that communication is appropriate.

Residents' cultural and spiritual beliefs are identified on admission and there is access to cultural and spiritual support if required. Informed consent is practised and written consent is obtained when required.

Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents. Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

Staff communicate with residents and family members following any incident and this is recorded in the resident's file. Residents, family and GP interviews confirmed that the environment is conducive to communication, issues are identified where applicable, and that staff are respectful of residents' needs.

There is a documented complaints management system that aligns with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Complaints are investigated and documented, with corrective actions implemented where required. A complaints register is maintained. There has been one complaint investigated by the Health and Disability Commissioners since the last audit.

Organisational management

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

Oceania Healthcare Limited is the governing body responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned.

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement meetings at the facility. Facility meetings are held that include reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

The facility has an incident and accident management system to record and report adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting.

The business and care manager provide operational oversight of the service. The clinical manager is a registered nurse and is responsible for clinical management and oversight of services and is supported by the regional clinical quality manager.

Human resource policies and procedures guide practice and there is evidence that human resource processes are being followed. There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. Staffing levels are adequate across the services.

Systems are in place to ensure the consumer information management system is protected from unauthorised 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.

Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plans are utilised to guide staff until the interRAI assessment is completed and the person centred care plan is developed and implemented. Care plans reviewed were individualised and risk assessments were completed including falls risks. The care plans are updated six monthly or more often if required. Relatives are notified if any changes occurs in a resident's health condition.

An activities programme is implemented appropriate to the age, needs and culture of the residents. Individualised plans are in place which are meaningful for residents and meets their interests, including those under 65 years old. The residents and families interviewed expressed satisfaction with the activities provided by the activities coordinators.

Medicine management policies and procedures are documented and residents receive medicines in a timely and safe manner. The medication systems, processes and practices are in line with the legislative and contractual requirements. Medication records were reviewed electronically. The general practitioner prescribes medications and completes regular and timely medical reviews of residents. Medication competencies are completed for all staff annually who administer or check medications.

The food service meets the nutritional needs of residents and ensures additional/modified nutritional requirements or special diets are catered for. Food is safely managed. The food control plan was sighted and residents verified satisfaction with meals.

Safe and appropriate environment

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

There is a current building warrant of fitness and an approved fire evacuation plan.

A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes equipment and electrical checks.

Residents' rooms provide single accommodation and are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Bathroom and showering facilities are provided throughout the facility and are easily accessible. Residents' rooms are spacious and some are of sufficient size to accommodate a couple if requested. The facility has a monitored call bell systems for residents to summon help, when needed, in a timely manner.

There are documented and implemented policies and procedures for cleaning and waste management. Cleaning and laundry services are provided seven days a week by household staff and monitored.

Essential security systems are in place to ensure resident safety. Six monthly trial evacuations are undertaken.

Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler and two restraints were in use at the time of audit. A restraint assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff members receive training relating to the management of challenging behaviour and restraint use.

Infection prevention and control

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

The infection prevention and control programme is reviewed annually for its continuing effectiveness and appropriateness. There are antibacterial dispensers and hand washing facilities for staff, visitors and residents throughout the facility. Staff education in

infection prevention and control was conducted according to the education and training programme and recorded in staff records reviewed. Staff members were able to explain and understood the principles of infection prevention and control.

Infections are investigated and appropriate antibiotics are prescribed according to sensitivity testing. Short-term care plans were utilised as required. The surveillance data is collected monthly for benchmarking. Interventions are in place to manage infections that present. No outbreaks have been reported 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	49	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	There are implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). All staff have received education on the Code as part of orientation and the annual education programme. Staff interviews confirmed their understanding of the Code as well as their obligations. Evidence that the Code is implemented in their everyday practice includes, but is not limited to: maintaining residents' privacy; providing residents with choices; encouraging independence; involving residents and family in decision making and ensuring residents are able to practise their own personal values and beliefs. Residents and family interviews and observation confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff are respectful towards residents and their families and residents receive information relevant to their needs.
Standard 1.1.10: Informed Consent Consumers and where appropriate their	FA	The organisation's informed consent policy provides the guidelines to ensure that all residents or their family will be informed about the management and care to be provided in order that they may arrive at a reasoned and non-pressured decision about any proposed treatment or procedure. It describes what consent involves and how it may be facilitated, obtained, refused and withdrawn. Cultural considerations are identified such as the

family/whānau of choice are provided with the information they need to make informed choices and give informed consent.		involvement of the wider whānau and allowing time for decision making. It ensures that staff members adhere to the legal and ethical requirements of informed consent and informed choice for health care services and service provision. The policy includes guidelines for consent for treatment, photographs, specific cares, collection and storage of information, and advance directives. The information pack provided on/prior to admission includes information regarding informed consent. The CM or RN discusses this with residents and their families during the admission process to ensure understanding. Staff receive orientation and training on informed consent and staff interviews confirmed they are aware of the informed consent process. There is an advance directive and an end of life decision policy to ensure that appropriate ethical concepts are upheld in resident treatment and care situations in relation to end of life. The policy defines the procedure for obtaining an advance directive and who may or may not make an advance directive. File reviews demonstrated that advance directives and resuscitation orders were completed in accordance with policy.
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	Observations and resident and staff interviews confirmed that residents may have access to visitors of their choice at any time. There are areas where a resident and family can meet in private. Observations and resident and family interviews confirmed that families were made to feel welcome in the facility. Interviews confirmed that residents are able to maintain existing community involvement with family and social networks. Resident interviews confirmed that residents are free to leave the facility when they so choose, for example to be involved in local social activities and family outings. The activities programme and the content of care plans include regular outings in the community. Staff interviews stated that all residents, including those under the young people with disabilities (YPD) contract, are supported and encouraged to access activities and resources in the community as well as family and networks if they so choose. There is facility, close to the entrance, for residents who are able, to store, charge and continue to use their mobility scooters in order to be mobile in the community and surrounding areas.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is	FA	The organisation's complaints policy outlines the complaints procedure that is in line with the Code and includes the expected timeframes for responding to a complaint. The complaint process and forms are made available as part of the admission pack and handbook. Residents and their families are reminded of the complaints process at resident meetings. The complaint forms are also available at the entrance to the facility. The BCM is responsible for managing complaints. The CM provides input into complaints of a clinical matter. An up-to-date complaints register is in place that includes: the date the complaint is received; the source of the

understood, respected, and upheld.		complaint; a description of the complaint; resolution and the date the complaint is signed off. Evidence relating to each lodged complaint is held in the complaints folder and register. Complaints reviewed indicated that complaints are investigated promptly and issues are resolved in a timely manner. Staff interviews confirmed that residents and family were encouraged to raise any concerns and provide feedback on services. Residents and family interviews confirmed that they were aware of the complaints process. Residents stated that they could raise any issues directly with management and that these are dealt with effectively and efficiently. Residents and family interviews confirmed an understanding of their rights to advocacy and how to access advocacy services in relation to the complaints process. There has been one complaint lodged with the Health and Disability Commissioner (HDC) since the previous audit relating to resident care. In response, the organisation had undertaken a review of the file and circumstances over a specified period and provided this information, inclusive of resident file documents and Oceania policies, to the HDC. Training records and the course outline demonstrated that additional training had been provided to all staff on restraint in response to the complaint. This included, but was not limited to, restraint types and enablers. Incidents relating to falls are reviewed by the BCM and CM. A falls team has been established to specifically monitor falls. The falls team has met monthly since September 2018 and will continue to meet until February 2019. The falls team reviewed monthly audits, including audits of alarm mats; falls in the period; the falls register and the implementation of interventions. Ongoing training has been provided on the completion of incident/accident forms to ensure staff understanding on implementing actions required and documenting communication with family. Completed incident/accident forms are reviewed by the falls team to determine if family and/or enduring power of attorney (EPOA) have been contacted and where this is not documented the team investigate to determine why this had not been done. Interview with the BCM advised that the organisation was awaiting the outcome of the HDC investigation and would formally respond to the family concerned, following the confirmation of the outcome from the HDC.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	New residents and their families are provided with information about the Code as part of an information pack and handbook provided on admission to the facility. The clinical manager (CM) or registered nurse (RN) also explains the Code to ensure understanding during the admission process. The pack includes information on the complaints process and advocacy service. The Code and associated information is also available in information brochures which are displayed at the entry to the facility and available to take away and read in private. Information on the Code is also displayed in posters in English and te reo Māori. Advocacy services can be accessed locally through the Nationwide Health and Disability Advocacy Service for residents if required. Resident meeting minutes and business care manager (BCM) interview identified that the advocate had attended resident meetings to discuss the advocacy service.

		Residents and family members interviewed were aware of the Code and the advocacy service.
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 organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code and ensure that a resident's right to privacy and dignity is upheld. Interviews and observation confirmed that staff knock on bedroom and bathroom doors prior to entering rooms and ensure that doors were shut when personal cares were being provided. Interviews and observation confirmed that conversations of a personal nature were held in private. Residents and families stated that they felt that resident privacy is respected. The organisation has a policy on sexuality and intimacy that acknowledges residents' rights to privacy and intimacy as identified by each resident. It includes: identifying resident needs; and responding to expressions of sexuality. Resident files and interviews and satisfaction surveys confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented, and upheld. There is an abuse and neglect policy that sets out the guidelines to: prevent; identify; report and correct incidences of abuse and neglect. It includes managing the risk to residents and staff arising from abuse or neglect. Staff receive orientation and annual training on abuse and neglect. Staff and interviews identified staff are aware of their obligations to report any incidences of suspected abuse. There were no documented incidents of abuse or neglect. Staff, resident, and family interviews confirmed that there was no evidence of abuse or neglect.
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 organisation has a Māori health plan/policy that demonstrates Oceania Healthcare Limited's commitment to ensuring residents who identify as Māori have their needs met in a manner that respects and acknowledges their individual and cultural values and beliefs. There is also a cultural competent services policy that describes for staff how culturally competent services should be delivered. Support for staff in providing culturally appropriate care, and for Māori residents and their families, can be sourced if required through linkages with local iwi. Staff receive training in cultural safety and values, and Māori health at orientation and as well as part of the mandatory annual education programme. There were no residents who identified as Māori at the time of audit. Staff interviews confirmed awareness of how culturally competent services would be delivered and were aware of the importance of the involvement of immediate and wider whānau in the delivery of care for any Māori residents.

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	Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family are involved in the assessment and the care planning processes. Information gathered during assessments includes identifying a resident's specific cultural needs, spiritual values, and beliefs. A review of residents' files confirmed that specific cultural needs identified in assessments are reflected in the residents' care plans. Assessments also include obtaining background information on a resident's spiritual and cultural preferences, which includes but is not limited to: beliefs; cultural identity; and church attendances. This information informs activities that are tailored to meet identified needs and preferences. The spirituality and counselling policy ensures access for residents to chosen a chosen spiritual advisor or counsellor. Weekly church services are held in different denominations for residents who choose to attend a service. A catholic priest is available to provide communion to residents who wish to receive this. Room blessings are provided, when required, through a lay person. Resident interviews and surveys confirmed that the services were responsive to individual resident's cultural needs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	There is policy to ensure that the environment for residents is free from discrimination; coercion; harassment; and financial exploitation. The policy describes for staff how this will be prevented and, where suspected, reported. Job descriptions include the responsibilities of the position, including ethical issues relevant to each role. Staff interviews confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. There were no complaints or incidents recorded since the previous audit relating to any form of discrimination, coercion or harassment. Staff are required to abide by the Oceania code of conduct. Staff mandatory training includes professional boundaries. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Resident and family interviews confirmed that staff maintain appropriate professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The facility implements the Oceania policies and procedures which are current and based on good practice and current legislation and guidelines. The policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice. There are relevant training programmes for all staff. Benchmarking occurs across all the Oceania facilities. Results of benchmarking is made available to staff through monthly meetings.

		Staff, resident and family interviews, residents' file notes and observation of service delivery confirmed that resident care was based on good practice guidelines.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy that sets out the process to guide staff to ensure there is open disclosure of any adverse event where a resident has suffered any unintended harm while receiving care. Completed incident forms, residents' records and family interviews demonstrated that family are informed if the resident has an incident/accident; a change in health or a change in needs. Family contact is recorded on family communication sheets in residents' files and on incident forms. Family and resident interviews confirmed that family are included in resident care planning meetings. Two monthly residents' meetings inform residents of facility activities. Family are invited to attend residents' meetings. Meetings also provide an opportunity to raise and discuss issues/concerns with management. Minutes of the residents' meetings sighted provided evidence that a wide range of subjects are discussed such as but not limited to: the results of internal audits; survey results; new residents and staff; and upcoming events. Residents are provided with a copy of the minutes from these meetings. Copies of the planned activities and the menu are also available to residents. Residents and staff are also informed of updates and events through the monthly newsletter, which provides information and updates on a range of subjects such as but not limited to: seasonal health issues (eg, hydration in the hot weather and winter influenza vaccinations); laundry and clothing labelling; upcoming events; and staff anniversaries. Residents and family interviews confirmed that the BCM and CM were approachable and available to discuss services and issues with residents and their families. There is policy that provides guidance and procedures for staff to ensure that residents who do not use English as their first language are offered interpreting services. It states that staff have access to a list of interpreting services and family may only interpret with a resident's consent. Interviews confirmed that interpreter services would be accessed through the local International Language School or the district health board (DHB), if required. At the time of the audit there were no residents who required an interpreter.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the	FA	The facility is part of the Oceania Group with the executive management team providing support to the facility. Communication between the service and Oceania executive management occurs monthly with the clinical and quality manager providing support during the audit. The monthly facility business status report provides the executive management with progress against identified indicators. Oceania has a documented mission statement, vision and values. These are displayed at the entrance to the facility. The values are also communicated to residents in each newsletter. In addition to the overarching Oceania business plan, the facility has a current business plan specific to Whitianga

needs of consumers.		Continuing Care that sets out the facility's business objectives of the facility and details the actions required to achieve these. There is evidence that the plan is reviewed and achievement against actions documented. The facility is managed by a BCM who is supported by a CM. The BCM had been employed at the facility in an administrative role for 10 years and as BCM for the last four years. The BCM has previous experience in finance and human resources management. The clinical care at the facility is overseen by the CM. The CM is a RN who has previous experience as a CM in an aged residential care (ARC) facility and as a practice nurse. The CM has been in this position for one year. The management team is supported in their roles by the Oceania executive and regional teams and have completed induction and orientation appropriate to their respective roles. The facility is certified to provide rest home and hospital level care and currently provides care for up to 54 residents with 18 rest home level beds and 36 hospital level beds. There were 51 beds occupied at the time of the audit. Occupancy included 27 residents requiring rest home level care and 24 requiring hospital level care. Review of the redesignation of 53 of the 54 bedrooms to dual purpose confirmed bedrooms were suitable for dual purpose use. The facility is spread out in a square around a central courtyard, with three wings. There is a main nurses' station central to one wing on one side of the facility and a nurses' station for the CM on the opposing side near reception. There are sufficient staff to meet the assessed level of need of all residents, noting the numbers of rest home and hospital level residents at the time. The facility has contracts with the DHB for the provision of rest home and hospital level care; general practitioner (GP) beds; respite care; post-acute care; and residential non-aged care (YPD services). Included in total occupancy numbers there was: 1 resident aged 64 years and assessed at hospital level care under the ARC agreement, having been identified and assessed by the NASC as 'close in age and interest to ARC'. Also included was; 1 resident assessed at hospital level care under the GP beds agreement; 1 resident assessed at rest home level care under the respite care agreement; and 2 residents assessed at rest home level care and 1 assessed at hospital care under the post-acute care agreement and 1 resident assessed at rest home level care under the YPD agreement aged 65 years.
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,	FA	During a temporary absence of the BCM, the CM is responsible for the day to day operation of the service and is supported by experienced RNs, the regional clinical and quality manager, and the regional operations manager. In the absence of the CM, RNs with the support and help of the regional clinical and quality manager, ensure continuity of clinical services.

appropriate, and safe services to consumers.		
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	The facility utilises Oceania's documented quality and risk management framework that is available to staff to guide service delivery. All policies are current and align with the Health and Disability Services Standards and reflect accepted good practice guidelines. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies are presented to staff at staff meetings and on the staff noticeboard. Policy updates are also provided as a part of relevant in-service education. Service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators such as: complaints; incidents and accidents; surveillance of infections; pressure injuries; falls and medication errors. There is evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data provides evidence that data is being collected and collated with the identification of trends and analysis of data. Where required, corrective action plans are developed, implemented, evaluated and closed out. There is communication with staff of any subsequent changes to procedures and practice through meetings and staff notices. Residents and family are notified of updates through the facility's resident meetings. Quality, health and safety and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. Staff reported that they are kept informed of quality improvements. Copies of meeting minutes are available for review in the staff room for staff that were unable to attend a meeting. Satisfaction surveys for residents and family are completed as part of the internal audit programme. The August 2018 surveys reviewed evidenced satisfaction with services provided and this was confirmed by resident and family interviews. The organisation has a risk management programme in place that records management of risks in clinical, environment, human resources and other areas specific to the facility. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly. There is a nominated health and safety representative who has undertaken health and safety training in the preceding two years. There is evidence of hazard identification forms being completed when a hazard is identified and that hazards are addressed and risks minimised. A current hazard register is available and is reviewed and updated annually or upon identification of a new hazard.

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	Policy and procedures reference essential notification reporting; for example, health and safety, human resources, and infection control. The BCM is aware of situations which require the facility to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles. These are reported to the appropriate authority by the Oceania support office and there is evidence of correct and accurate reporting. There had been four events requiring essential notifications to external agencies since the last audit. These included a: pressure injury; resident challenging behaviour; medication error); and an extended time power outage. Staff interviews confirmed that all staff are encouraged to recognise and report errors or mistakes. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events. Staff records reviewed demonstrated that staff receive education at orientation on the incident and accident reporting process. There is an implemented accident/incident reporting process and incident reporting forms are available throughout the facility. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on an accident/incident form which is signed off by the BCM. There is input from the CM on incidents of a clinical matter. Incident reports selected for review evidenced the resident's family had been notified, an assessment had been conducted and observation completed. There is evidence of a corresponding note in the resident's progress notes and notification of the resident's nominated next of kin where appropriate. Corrective actions arising from incidents were implemented. Information gathered is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Results of accident/incident data is benchmarked nationally with other Oceania facilities and trends are analysed. Accident/incidents are also discussed at quarterly regional cluster meetings. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared at health and safety and staff meetings.
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	Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; a signed employment agreement; position specific job description; police vetting; and identification verification. An appraisal schedule is in place and all staff files reviewed evidenced a current performance appraisal. There are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff and that require them, including, GPs, pharmacists and dietitian. An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks, including personal cares. Interviews confirmed that new staff are supported and buddied into their new roles.

		The organisation has implemented the Oceania documented role specific mandatory annual education and training modules. Education session attendance records evidenced that ongoing education is provided. There are systems and processes in place to ensure that all staff complete their required training and ongoing competencies. Training records evidenced that staff have undertaken a minimum of eight hours of relevant training. The CM and three RNs have completed interRAI assessment training and competencies. One other RN is booked for interRAI training. Annual competencies are completed by care staff and include for example: restraint; infection control; hoist use; medication management; wound management and fire training. Additional one-off training was also provided to all staff on restraint.
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 mix in order to provide safe service delivery. Rosters sighted reflected that staffing levels meet resident acuity and bed occupancy. Rosters are available to staff at least two weeks in advance and staffing levels are reviewed to accommodate anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Casual and part-time staff are available to provide additional shifts if required. There are sufficient RNs and health care assistants (HCA), available to safely maintain the rosters for the provision of care, to accommodate increases in workloads and acuity of residents such as additional hospital level residents. The facility is spread over three wings on one floor that accommodates a mix of rest home and hospital level residents. Rosters sighted reflected adequate staffing levels to meet resident acuity, bed occupancy and the requirements of the contract. There are 65 staff, including: the management team; administration; clinical staff; activities staff; and household staff. Household staff include: cleaners; kitchen staff and laundry staff who provide services seven day a week. A review of rosters demonstrated that there is at least one RN on each shift. The BCM and CM are on call after hours, seven days a week. Observation of service delivery confirmed that residents' needs were being met in a timely manner. Residents and family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed they are able to complete their scheduled tasks and resident cares within their rostered shift.
Standard 1.2.9: Consumer Information	FA	Residents' records are maintained in hardcopy and electronically. Records reviewed demonstrated that residents' information, including progress notes, are legible and entered into the resident's record in an accurate and timely

Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		manner, identifying the name and designation of the person making the entry. Residents' progress notes are completed detailing resident response to service provision whenever there is a change in resident condition and at least twice in 24 hours for hospital level residents and at least three time per week for rest home level residents. There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of obligations and procedures for maintaining confidentiality of resident information. Resident care and support information can be accessed in a timely manner and when not in use is protected from unauthorised access by being locked in a cabinet in a staff office. Archived records are securely stored and easily retrievable. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the resident and/or resident's family where applicable. The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel only.
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 into the service is facilitated in a timely and respectful manner. Pre-admission packs are provided for families and residents prior to admission. Admission agreements were signed and dated. The facility requires all residents to have Needs Assessment and Service Coordination Service (NASC) assessments prior to admission to ensure they are able to meet the resident's needs. If residents are directly admitted from the DHB the assessment is completed by authorised personnel. The RNs admit new residents into the facility and RNs are responsible for completing all assessments. This was confirmed at interview. Evidence of the completed admission records were sighted. The RNs receive hand-over from the transferring agency, for example, the hospital or NASC, and utilise this information when undertaking the initial assessment. The organisation seeks update information from the NASC or the GP for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Residents records reviewed contained all demographic details, service agreements and family contact details in accordance with contractual requirements.
Standard 1.3.10: Transition, Exit,	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented procedures to ensure exit, discharge or transfer is undertaken in a

Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		timely and safe manner. The service uses the DHB 'yellow envelope' system to facilitate the transfer of residents to and from acute care services. There is open communication between services and appropriate information is provided for ongoing management of the resident. The CM reported that they include copies of the resident's records, including GP visits, medication record, current PCCPs, any up and coming hospital appointments and other medical alerts when a resident is transferred to another health provider.
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	Medicine management policies and procedures are implemented and include processes for safe and appropriate prescribing, dispensing and administration of medicines. The treatment room is accessible by the relevant personnel and was observed to be free from heat, moisture and light, with medicines stored in original dispensed packs and folders. Two medication trollies were available and when not in use, were stored in the locked treatment room. An electronic medicine system is utilised. The electronic records were reviewed and contained the required documentation inclusive of prescribing and dated photo identification. All entries were dated and allergies/sensitivities were recorded. The three monthly GP reviews were dated. Evidence of medication reconciliation was observed in the resident's records reviewed. The drugs are checked in the required timeframes and documentation evidenced medication management requirements are met. Any discontinued or expired medicines are returned to the contracted pharmacy. Sharps bins were sighted as part to the infection prevention and control protocols. Medication administration was observed. The two staff members checked the identification of the residents, completed crosschecks of the medicines in the blister packs and then signed off electronically after the medicines were administered. Education in medicine management is conducted. Staff authorised to administer or to check medications complete medication competencies and annual competencies were reviewed. Self-administration of medicine policies and procedures are in place and sighted. There were no residents who self-administered their own medication at the time of audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and	FA	The residents' individual food, fluids and nutritional needs are met. Residents are provided with a well-balanced diet which meets their cultural and nutritional requirements. The meals are prepared and cooked on-site. The four weekly summer menu plans were reviewed by the organisation's dietitian in September 2018. The menu review is based on the Ministry of Health nutritional guidelines for the older people in long-term residential care. A dietary assessment is completed by the RNs on admission. This information is shared with the kitchen staff to ensure all

nutritional needs are met where this service is a component of service delivery.		needs, food allergies or sensitivities, likes, dislikes and special diets are catered for. The facility provides modified diets to meet the dietary needs of the residents. Two whiteboards were visible in the kitchen which contain important reminders about meals, beverages and modified diets as well as food preferences of residents. The cook/kitchen manager interviewed has worked at this facility for three years, works five days a week and is supported in the kitchen by a kitchen hand. A relief cook covers the weekend. Staff working in the kitchen have current food handling certificates. The cook/kitchen manager confirmed documentation of kitchen routines and the cleaning schedules were reviewed and implemented. Nutrition and safe food management policies define the requirements of all aspects of food safety. The cook/kitchen manager is responsible for ordering of supplies. Labels and dates on all containers and records of food temperature monitoring are maintained. The chiller, fridges and freezer temperatures are monitored. The service has a food control plan expiry March 2019 which is displayed. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply 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 an adequate documented process for the management of declines to entry into the facility. Records of enquiry are maintained and in the event of decline information is given regarding alternative services and the reason for declining services. The CM assesses the suitability of residents and used an enquiry form with appropriate questions regarding the specific needs and abilities of the resident. When residents are not suitable for services provided, support is provided to find an appropriate care alternative. When a resident's needs change, a referral for reassessment to the NASC is made and a new placement is found in consultation with the family/whānau as described in staff interviews. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded	FA	The resident's needs, support requirements and preferences are collected and recorded within required timeframes. The RNs or the CM complete a variety of risk assessment tools on admission. A copy of the interRAI assessment completed within three weeks after admission was in the records reviewed. Additional assessments were sighted in the resident's records reviewed including, for example, a falls risk assessment and subsequent management plan, medical assessments completed by the GP, pain assessments and a recreational assessment completed by the activities coordinator. The records reviewed evidenced baseline recordings for weight management and vital signs with monthly

in a timely manner.		monitoring and more often if required. Staff interviews confirmed that the families were involved in the assessment and review processes. If the family are contacted, this is recorded on the progress records and the family communication record sheet. The outcomes of the assessments are used in creating an initial care plan, the PCCP and a recreational plan for each individual resident.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	An initial plan of care is developed on admission and the PCCPs are developed within three weeks of admission. Care plans reviewed were resident focused, integrated and promoted continuity of service delivery. The facility uses an integrated document system where the GP, allied services, the RNs and enrolled nurses (EN), activities, and other visiting health providers write their care notes. The resident records reviewed had sections, separating key information for ease of reference. Interventions sighted were consistent with the assessed needs and best practice. Plans were documented for residents who were experiencing pain and for those residents who were frequently predisposed to falling to guide staff in service provision. Goals documented included realistic, achievable and clearly documented interventions. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents receive adequate and appropriate services meeting their assessed needs and desired outcomes. In records reviewed interventions were documented for each goal in the PCCPs. Other considerations like pain management, wound care, falls management, dietary needs, likes and dislikes, appropriate footwear, continence management, walking and hearing aids were included in the PCCPs. There were adequate supplies of continence and wound care products observed and available for residents. Interview with the GP confirmed clinical interventions were effective and appropriate. Review of records indicated that interventions documented by allied health providers were included in the PCCP (eg, the dietitian, NASC and other health visitors). Resident and family involvement in the development of goals and review of care plans is encouraged. InterRAI assessment are discussed with the resident and family as able. Multidisciplinary team meetings are conducted by the RNs who discuss and review the PCCP and make changes as required. All resident records reviewed during the on-site audit were signed by either the resident or by their families.
Standard 1.3.7: Planned Activities Where specified as part	FA	The activities programmes reviewed confirmed that independence is encouraged and choices are offered to residents. Two activities coordinators are in place with one responsible for planning the recreational programme. The activities programme is provided six days a week by the activities coordinators. The second activities

of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		coordinator is employed on Friday and Saturday. With both activities coordinators working on Fridays, this provides an opportunity for the activities programme documentation and planning to be completed. The programme was displayed in the facility and the residents receive a copy of the weekly activities. The activities programme reviewed had been signed off by a diversional therapist. A range of activities are provided and include physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. During the onsite visit, activities observed included a men's club, a church service, residents listening to music, craft activities and one-on-one activities. Outings into the community are encouraged and enjoyed by the residents interviewed. Entertainment for residents is provided on a regular basis. Residents under 65 years of age have their own YPD social and recreational/care plan with goals. A Monday to Sunday plan was sighted with times of day and activities planned documented inclusive of activities in the community. Residents' and family confirmed they were satisfied with the activities programme. Resident records reviewed during the on-site audit had current activity assessments in place. Resident records reviewed demonstrated that review of activity plans were completed every six months as part of the multidisciplinary review or when the condition of the resident changes.
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 records. If any change is noted, it is reported to the RN. The progress records reflect daily responses to interventions and treatments. The resident records evidenced the six-monthly re-assessment interRAI reviews had been completed in conjunction with the formal care plan review process. Clinical reviews were documented in the multidisciplinary review records which included input from the GP, RNs, ENs, HCAs, activities coordinator and members of the allied health team. Short-term care plans evidenced review and evaluation of progress as clinically indicated for wounds, infections, and post falls. When necessary and for unresolved problems these are transferred to the PCCP. Residents and families interviewed confirmed involvement in the evaluation of progress and resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for	FA	The CM interviewed stated that residents are supported in accessing or in referral to other health and disability providers. The RNs refer residents for further management to the GP, dietitian, physiotherapist, mental health services and NASC as needed. The GP confirmed involvement in the referral process. The service follows a formal referral process to ensure continuity of service delivery. The review of resident records included evidence of recent referrals to the NASC

access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		and to specialists. Some residents had been referred to Thames Hospital or to Waikato Hospital. Copies of referrals are kept in each individual resident's record. The resident and the family are kept informed of the referral process as verified in documentation and interviews. Any acute/urgent referrals are attended to immediately such as the GP attending the resident and/or direct transfer to Waikato DHB. Documentation evidenced the referral and transfer processes are followed by staff when this is required.
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 policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling and disposal of and collection of waste. The hazard register is available and current. Current material safety data posters are available and accessible to staff in relevant places in the facility. Staff receive training and education in waste management as a component of the mandatory training programme. Interviews and observations confirmed that there is sufficient personal protective clothing and equipment provided, such as aprons, gloves and masks. Interviews confirmed that the use of personal protective clothing and equipment is appropriate to the recognised risks. Observation confirmed that personal protective clothing and equipment was used in high-risk areas. At the time of the audit seven retirement village units were being constructed for the facility. Health and safety and hazard measures had been implemented, including a dust screen on the fence perimeter, facing the facility. Observation and resident interviews confirmed this to be effective.
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 at the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation. There is an implemented preventative and reactive maintenance schedule. This includes monthly maintenance checks of all areas. Staff identify maintenance issues in a maintenance log book. These are reviewed daily by the maintenance person who has been in the role for three years. Staff interviews and a review of maintenance requests confirmed awareness of the processes for maintenance requests and that repairs were conducted in a timely manner. Staff interviews and visual inspection confirmed there is adequate equipment to support care, including care for residents with disabilities. The facility has an annual test and tag programme and this is up to date, with evidence of checking and calibration of biomedical equipment. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained. Inspection confirmed the van has a current registration, warrant of

		fitness, extinguisher and functioning hoist. Hot water temperatures are monitored monthly and were noted to be maintained within recommended temperature ranges. A review of temperature assays and an interview with the maintenance person confirmed that where hot water temperatures have been above the recommended safe temperature, action is taken and rechecking of the temperature occurs to ensure a safe temperature is maintained. All resident areas can be accessed with mobility aides. There is a paved courtyard; grassed areas; and outdoor seating and shade that are able to be accessed freely by residents and their visitors. Observation and residents and family interviews confirmed that residents can move freely around the facility and that the accommodation meets their needs.
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 sufficient numbers of accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility. There are 20 rooms that have full ensuite facilities, 16 with a shared toilets between 2 rooms; 4 with a shared ensuites between 2 rooms and the remaining rooms have access communal toilet and bathroom facilities. Communal toilets have a system to indicate vacancy and have sufficient disability access. A visitor toilet is located near the entrance to the facility. All shower and toilet facilities have call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence. Observation at the time of the audit confirmed that residents were supported to access communal facilities in a manner that was respectful and preserved resident dignity.
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	At the time of the audit all residents had their own room and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. There are some rooms of sufficient size to accommodate two residents should a couple wish to share. The BCM advised that when this had occurred the second bedroom was used by the couple as a seating/lounge area. Resident interviews confirmed that there was sufficient space to accommodate personal items; furniture; equipment; and staff as required. Residents and their families are able to personalise their rooms. Residents' rooms viewed were personalised with their own possessions. Possessions in residents' rooms included residents' own personal pieces and memorabilia. Observation confirmed appropriateness to the setting and that furniture was arranged in a manner that enabled residents to mobilise freely.

		There are designated areas to store equipment such as mobility scooters, wheel chairs, walking frames and commodes safely and tidily. Hoists are stored in the corridor during periods of high use, such as morning showers, and observation confirmed there is sufficient space for residents and staff to move freely in corridors when this occurs. Observation confirmed that the 53 of 54 beds to be redesignated as dual purpose, had sufficient space for manoeuvrability of equipment, where applicable, and residents, staff and visitors to move freely.
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	There is a main lounge and dining room in one wing of the facility, adjoining the kitchen. In addition, there is a small lounge each of the other three wings. All internal communal areas have seating and a view of gardens. In addition, there are external areas with seating and shade. All areas can be easily accessed by residents and staff. There are sufficient areas for residents to access with their visitors if they wish. This includes places where YPDs can find privacy. Observation and residents and family interviews confirmed that residents can move freely around the facility and that the accommodation meets their needs. There is an activities area for storing activities equipment and resources and for residents to participate in crafts. A lounge area is also used for activities. There are sufficient facilities for all residents to eat meals communally and most residents were observed to have their meals with other residents in communal dining room. However, residents can choose to have their meals in their room if they wish.
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	Facility laundry, including residents' personal clothing, is completed on site. Colour coded, covered laundry trolleys and bags were observed to be used for transport. Residents and family members stated that the laundry standard met their requirements. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen. There is clear delineation and observation of clean and dirty areas in the laundry area. There is one laundry staff member on duty for six hours, seven days a week. There are cleaners on duty each day, seven days a week. Cleaning duties and procedures are clearly documented, to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemicals on a trolley when cleaning and is aware of the need to keep the trolley with them at all times. Health care assistants undertake some laundry duties in the evenings. Cleaning staff also assist with meals service delivery in the mornings. Interview and observation confirmed that where household staff have more than one role, there is clear delineation between, and separation of, the roles of cleaning; laundry and care giving.

		Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility with alcohol gels in various locations. The effectiveness of cleaning and laundry processes are monitored through the internal audit process; resident and family surveys and meetings, with no significant problems identified. Resident and family interviews and observation noted the facility to be clean and tidy.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Staff files and training records demonstrated that orientation and annual training includes emergency and disaster procedures and fire safety. An approved fire evacuation plan was sighted. Staff interviews and documentation confirmed that fire drills are conducted at least six monthly. There is a monitored fire alarm; a sprinkler system installed throughout the facility and exit signage displayed. Training records demonstrated that relevant staff have undertaken fire warden training. The RN on duty is the nominated fire warden for each shift and at least one RNs on each shift has received fire warden training. The staff competency register evidenced RNs and ENs have current first aid certificates where required. There is at least one staff member on each shift with a current first aid certificate. The RNs and ENs also complete cardiopulmonary resuscitation training. There are sufficient supplies to sustain staff and residents in an emergency situation including alternative energy and utility sources that are available in the event of the main supplies failing. These include gas cylinders; a barbeque and gas bottles; emergency lighting; sufficient food, water, and continence supplies. The BCM advised the facility has recently decommissioned their emergency generator, as a recent upgrade the local electricity supply system has resulted in an improved and reliable electricity supply. The service's emergency plan is sufficient to include the considerations of all levels of resident need, including YPD residents. There are call bells to summon assistance in all resident rooms and bathrooms. Call bells and sensor mats are checked monthly by the maintenance person. Observation on the days of the audit and resident and family interviews confirmed that call bells are answered promptly. The organisation has a security policy and there are security systems in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building; the facility being locked and checked in the evenings; and restricted entry afterhours at night. There are security cameras at entrance points in the facility. There is a direct call number to summon police assistance if required.
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	All residents' rooms and communal areas accessed by residents have safe ventilation and sufficient external windows providing natural light. The external temperature on the days of the audit was noted to be hot. However, the environment in all resident areas was noted to be maintained at a satisfactory temperature. Fans and open doors were observed to provide cooling over summer. Some areas had reverse cycle air cooling systems (heat

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		pumps). The main source of heating in the winter is via ducted ceiling heating. Some rooms have wall panel heaters. There are systems in place to obtain feedback on the comfort and temperature of the environment. Care staff ask residents, as part of their daily routine, if the temperature of their room is comfortable. Resident and family interviews confirmed that the environment was maintained at a comfortable temperature and there were no issues identified with the temperature of the facility. There are designated shaded external smoking area for residents and steps in place to ensure that smoking does not impact on other residents or staff. At the time of the audit there were five residents who smoked.
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 responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The CM is the infection control nurse (ICN) and there is a job description in place. The infection prevention and control programme has been implemented to minimise the risk of infection to resident, staff and visitors. The programme is guided by the infection control manual. The programme is reviewed annually by the support office team. Infection control matters, including surveillance are reported monthly to the CM. Infection control is on the monthly quality and staff meeting agenda. The CM reported that hand-washing audits were completed several times during the year as per the audit schedule reviewed. Hand washing signage was observed around the facility to remind staff and residents of the importance of effective hand washing. Pandemic supplies, are available and checklists were reviewed.
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 ICN/CM, BCM, a HCA, an RN, and a kitchen and laundry representative form the infection prevention and control committee. The committee is appropriate for the size and nature of this service. The ICN has attended Waikato DHB infection control education and completed an online infection control course (certificates sighted).There is adequate human, physical and information resources to implement the infection control programme and to meet the needs of the organisation.
Standard 3.3: Policies	FA	Policies and procedures to be implemented within their facilities are developed by the national Oceania infection control committee and reflect accepted good practice and relevant legislative requirements. Policies and

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.		procedures are readily available and implemented at the facility. These policies and procedures are practical, safe and appropriate for the type of service provided.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The organisation provides relevant education on infection control to service providers, support staff and residents. The infection control education is provided by either the CM or by the RNs, who are all are trained to provide appropriate education. The education provided includes hand washing and standard precautions as additional infection control training. A record of all education provided is maintained. Residents interviewed were aware of the importance of hand washing. The facility maintains regular in-service trainings for infection control including standard precautions, personal protective equipment, cleaning infectious diseases and hand washing. Training records were sighted that are aligned with the Oceania training planner. Training on the influenza vaccination programme is also provided and isolation techniques if and when needed. There were no residents using isolation at the time of this audit
Standard 3.5: Surveillance Surveillance for infection is carried out in	FA	Surveillance is appropriate to that recommended for long-term aged related care facilities and includes, for example, infections of the urinary tract, wound, soft tissue, pressure injuries, fungal, eye, gastro-intestinal, upper and lower respiratory tract and skin conditions such as scabies. The ICN reviews all reported infections and these are documented. Any new infections and required management plans are discussed at the time of handover

accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		between the shifts to ensure early interventions occur. Monthly surveillance data is collated and analysed to identify if any trends, possible causative factors and required actions. Results of the surveillance programme are shared and feedback to staff via regular meetings and at staff handovers. Graphs are produced that identify any trends for the year and comparisons against previous years and this is reported by the ICN and the infection control committee. The infection control surveillance register includes monthly infection logs and antibiotic use. The organisation has an internal benchmarking system. Infections are investigated and appropriate plans of action were sighted in meeting minutes. There have been no outbreaks of infection since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint minimisation and safe practice policies and procedures provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the CM. A RN is currently orientating to this role. The restraint coordinator provides support for enabler and restraint management at the facility. When interviewed the CM understood of the organisations policies, procedures and the responsibilities for this role. On the days of audit, two residents were using a restraint (bedrails) and one resident was using an enabler (bedrail). These were used as the least restrictive and the enabler was used voluntarily at the residents' request. The restraints were used as a last resort when all other alternatives had been explored.
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 restraint minimisation and safe practice policies and procedures meet the requirements of the standard. The facility maintains a process for determining approval of all types of restraints used. The restraint approval group is made up of the restraint coordinator and the GP. The restraint approval group is responsible for the approval of the use of restraints and the restraint processes. Restraint approval group meeting minutes were sighted. The meetings are held two monthly. Staff interviewed and resident records evidenced review of restraint occurs. The two restraints in use had been approved and family involvement was documented in the records reviewed. The use of the restraints and the one enabler is documented in the individual PCCPs. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed and from interview with staff.

Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Registered nurses undertake the assessments. Restraint assessments include identification of restraint related risks; underlying causes for behaviour that requires restraint; existing advance directives; past history of restraint use; history of any abuse and/or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes and possible alternatives to restraint. Evidence of family involvement in the decision making/EPOA was on the record in each case.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Before implementing the use of restraint, the restraint coordinator utilises other means to prevent the resident from incurring injury, for example, the use of low beds, mattresses and sensor mats. Restraint/enabler consents reviewed were signed by the GP, the resident (where applicable), family and the restraint coordinator. The restraint monitoring forms were completed by the ENs and the HCAs. The records reviewed evidenced that restraints were incorporated in the PCCPs and reviewed three monthly and discussed earlier at the staff meetings. The restraint register is maintained and 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 and PCCPs are evaluated six monthly. Reviews include the effectiveness of the restraint use, restraint related injuries (if any) and whether the restraint is still required. The resident and the family are involved in the evaluation of the restraints effectiveness and continuity. Family interviewed confirmed their satisfaction with the restraint process. Documentation was sighted in progress records of the resident regarding restraint related matters. Restraint minimisation and safe practices are reviewed. The evaluation covers all requirements of the standard. Education is provided at the annual Oceania mandatory study days. All staff except for one HCA have completed the restraint competencies. Education is provided at the monthly staff meetings. Additional training has been provided on restraint policies, use of bed rails and options for bed rail restraint.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and	FA	The facility demonstrated the monitoring and quality review of the use of restraints. The internal audit schedule was reviewed and included restraint minimisation reviews. The content of the internal audits included the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff knowledge and good practice is also included in the quality reviews. Staff monitor restraint related adverse events while restraint is in use. Any changes to policies, guidelines, education are implemented if indicated. Data reviewed, minutes and interviews with staff including care staff and RNs confirmed that the use of restraint has reduced and is only used

quality review of their use of restraint.		if and when necessary.

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.