

Oceania Care Company Limited - Eversley Rest Home and Village

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:

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| Legal entity: | Oceania Care Company Limited | | |
| Premises audited: | Eversley Rest Home and Village | | |
| Services audited: | Rest home care (excluding dementia care); Dementia care | | |
| Dates of audit: | Start date: 19 February 2019 | End date: 20 February 2019 | |
| Proposed changes to current services (if any): | None | | |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 46 | | |

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 |
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| | 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 |
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| | 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

Eversley Rest Home and Village is part of Oceania Healthcare Limited. The facility is certified to provide services for up to 50 residents requiring rest home and dementia level of care. There were 46 residents at the 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 and family, management, staff, and a general practitioner.

There are six areas identified at this audit as requiring improvement. These relate to service delivery timeframes; initial care plans; care plan evaluations; short-term care plans; review of the infection control programme and infection control surveillance.

Consumer rights

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

Residents' cultural and spiritual beliefs are identified as part of the assessment process 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 general practitioner 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 have been no complaints to external agencies since the last audit.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
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Oceania Healthcare Limited 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. 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, 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 role specific orientation programme and ongoing training is provided. There is a documented rationale based on best practice for determining staffing levels and skill mix in order to provide safe service delivery. 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

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Residents' clinical records evidenced that residents have been assessed as requiring either rest home or dementia level of care prior to their admission to this facility. InterRAI assessments, other risk assessments, care plans, and evaluations are completed by registered nurses. Interviews confirmed residents and their families are informed and involved in care planning and the evaluation of care. Handovers, diaries, medical and allied health notes guide continuity of care.

The activities programme provides residents with a variety of individual and group activities. Community outings are arranged. Entertainers and community groups are invited to participate in the programme.

Medicines are managed according to legislation and guidelines and are implemented using a computerised system. Staff responsible for medication management have attended annual education and completed annual medication competencies.

All food is cooked on site. Nutritional needs of residents are assessed on admission and additional requirements and/or modified needs are met. The menu is reviewed by a dietitian at organisational level. Residents interviewed confirmed satisfaction with the food service.

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

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. The facility has a monitored call bell system 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 services, provided seven days a week by household staff, are monitored. Laundry services are provided offsite.

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 Oceania Healthcare Limited policies and procedures on restraint and enabler use are current and reference best practice and legislation. The facility is restraint free. Staff receive training including the required aspects of restraint and enabler use, alternatives

to restraint and dealing with challenging behaviours. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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| 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. | | Some standards applicable to this service partially attained and of low risk. |
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Infection control management systems are in place to minimise the risk of infection to residents, visitors and staff. The infection control nurse is responsible for the infection prevention and control at the facility, with support from management and staff. Infection control education is provided to staff at orientation and at ongoing education study days.

Infection data is collated monthly, analysed and reported at facility meetings and to the Oceania Healthcare Limited support office.

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) |
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| Standards | 0 | 40 | 0 | 2 | 3 | 0 | 0 |
| Criteria | 0 | 87 | 0 | 2 | 4 | 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) |
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| 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 |
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| Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation. | FA | <p>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).</p> <p>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 and 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 for example, preferred shower times, food, clothing and activities; encouraging independence; involving residents and family in decision making and ensuring residents are able to practise their own personal values and beliefs.</p> <p>Residents and family interviews and observation confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Observation and resident interviews confirmed that staff are respectful towards residents and their families. Resident interviews confirmed they receive information relevant to their needs.</p> |
| Standard 1.1.10: Informed Consent Consumers and where appropriate | FA | <p>The organisation's informed consent policy provides the guidelines for staff. It ensures that all residents or their family are informed about the management and care to be provided. This is to</p> |

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| their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | | <p>ensure 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 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.</p> <p>Information regarding informed consent is included in the information pack provided on admission. The BCM 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.</p> <p>There is an advance directives 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.</p> |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>An advocacy policy and provides guidance for staff to ensure that residents and their families have a right to be represented and express views or concerns about their situation. It includes making them aware of the availability of advocacy services and support access to advocacy services. Information regarding the availability of the Nationwide Health and Disability Advocacy Service is included in the information packs provided to residents and family on admission to the facility. Additional advocacy services brochures are also available at the facility reception. The complaints policy also includes making residents aware of their right to advocacy when making a complaint.</p> <p>Staff interview confirmed that advocacy services can also be accessed on behalf of residents externally through the Nationwide Health and Disability Advocacy Service if required. Resident and family interviews confirmed awareness of the availability of advocacy.</p> <p>Family and resident interviews confirmed that the facility provides opportunities for the family to be involved in decision making, they are aware of the right to advocacy and the advocacy service available.</p> |
| Standard 1.1.12: Links With Family/Whānau And Other | FA | <p>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.</p> |

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| <p>Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | | <p>Observations and resident and family interviews confirmed that families are made to feel welcome in the facility.</p> <p>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 walk or sit in the adjacent park; be involved in local social activities and family outings. The activities programme and the content of care plans include regular outings in the community.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>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. The complaint forms are also available at the entrance to the facility along with a post box to submit the complaint.</p> <p>The BCM is responsible for managing complaints. An up-to-date complaints register is in place that includes: the date the complaint is received; the source of the 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 and BCM interview indicated that complaints are investigated promptly and issues are resolved in a timely manner.</p> <p>Staff interviews confirmed that residents and family are encouraged to raise any concerns and provide feedback on services. Residents and family interviews confirmed that they are aware of the complaints process. Residents and family stated that they could raise any issues directly with management and that these are dealt with effectively and efficiently.</p> <p>There have been no complaints to external agencies since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>New residents and their families are provided with information about the Code as part of an information pack provided on admission to the facility. The business care manager (BCM) also explains the Code to ensure understanding during the admission process. The pack includes information on the complaints process and advocacy service.</p> <p>Information on the Code is also displayed in posters in English and te reo Māori at the entrance to the facility. The Code and associated information are also available in information brochures which are displayed at the reception in the facility and available to take away and read in private.</p> |

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| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>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.</p> <p>Resident, staff and family interviews and observation confirmed that staff knock on doors prior to entering rooms, ensure doors were shut when personal cares were being provided and residents were suitably attired when taken to the bathroom. Interviews and observation confirmed that conversations of a personal nature were held in private. Residents and family member interviews confirmed that resident privacy is respected. A quiet room/sunroom is available for residents to meet with family and/or make phone calls.</p> <p>The organisation has a policy on sexuality and intimacy that acknowledges residents' rights to privacy and intimacy as identified by the individual resident. It includes identifying resident needs; and responding to expressions of sexuality. Resident and family interviews and observation confirmed that residents choose their own clothing to wear each day, and were observed to and be wearing makeup and personal adornments of their choice.</p> <p>Resident files, staff and resident interviews and satisfaction surveys confirmed that individual religious, social preferences, values and beliefs were identified, documented, and upheld. However, cultural needs were not always reflected in initial care plans (refer to 1.3.5.2).</p> <p>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 interviews identified that staff are aware of their obligations to report any incidences of suspected abuse. Staff, resident, and family interviews confirmed that there was no evidence of abuse or neglect. There were no documented incidents of abuse or neglect.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | FA | <p>The organisation has a Māori health plan/policy that demonstrates Oceania Healthcare Limited's (Oceania) 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.</p> <p>Support for staff in providing culturally appropriate care, and for Māori residents and their families, can be sourced if required through the district health board (DHB) Māori health team. Staff receive training in cultural safety and values at orientation and as well as part of the mandatory annual education programme. There were two residents who identified as Māori at the time of audit.</p> |

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| | | <p>Approximately eight staff identified as Māori, two of whom were learning te reo Māori.</p> <p>Staff interviews confirmed awareness of how culturally competent services would be delivered and were aware of the importance of the involvement of whānau in the delivery of care.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | FA | <p>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 assessment and care planning processes.</p> <p>Assessments 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. A review of residents' files confirmed that specific cultural needs identified in assessments are reflected in the residents' activities and long-term care plans. However, this is not consistently documented in the initial care plan (refer to 1.3.5.2).</p> <p>The spirituality and counselling policy ensures access for residents to a chosen spiritual advisor or counsellor. An interdenominational church service is held at the facility mid-week for residents who chose to attend a service. Alternatively, residents are able to attend their chosen church service in the community with their families. A hospital chaplain also visits residents on a regular basis. The divisional therapist, who is a celebrant, performs room blessings when a resident has died.</p> <p>Resident interviews and surveys confirmed that the services were responsive to individual resident's cultural needs.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | <p>The organisation has policy to ensure 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.</p> <p>Job descriptions include the responsibilities of the position, including ethical issues relevant to each role. Staff interviews confirmed awareness of their obligation to report any evidence of discrimination, abuse and neglect, harassment and exploitation.</p> <p>There were no documented complaints or incidents recorded since the previous audit relating to any form of discrimination, coercion or harassment.</p> <p>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</p> |

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| | | appropriate professional boundaries. |
| Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard. | FA | <p>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.</p> <p>All staff complete the relevant training programmes. Data is entered electronically onto the Oceania database and benchmarking occurs across all Oceania facilities. Staff interviews and monthly meeting minutes identified that the results of benchmarking are made available to and discussed with staff.</p> <p>Staff, resident and family interviews, residents' file notes and observation of service delivery confirmed that resident care was based on good practice guidelines.</p> |
| Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | <p>An open disclosure policy sets out the process to guide staff to ensure there is open disclosure of any adverse event where a resident has experienced 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 incident forms and in residents' files.</p> <p>Family and resident interviews confirmed that family are included in resident care planning meetings. Two monthly residents' forums inform residents of facility activities. Resident and family interviews confirmed that they are invited to attend resident meetings. Meeting minutes sighted confirm that residents and family are informed of staffing; facility matters such as gardening and kitchen purchases; activities such as wine tastings, upcoming entertainers and guest speakers; and resident movements. Meetings also provide an opportunity to raise and discuss issues/concerns with management. Copies of the activities plan and the menu are also available to residents. On alternate months to the resident forums, the facility holds two monthly family forums for family members of residents with dementia. The forum provides a supportive environment for family members to share and learn about dementia, by providing practical solutions and resources for residents' families.</p> <p>Residents and family interviews confirmed that they felt comfortable in approaching the BCM and senior staff to discuss services and issues and stated that any concerns raised and queries were addressed promptly.</p> <p>Policy 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. The BCM interview</p> |

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| | | confirmed that interpreter services would be accessed through the DHB if required. At the time of the audit there were no residents who required an interpreter. |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>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.</p> <p>Oceania has a documented mission statement, vision and values. These are displayed close to the facility entrance and included in the information pack provided to residents on admission.</p> <p>In addition to the overarching Oceania business plan, the facility has a current 2019 - 2021 business plan specific to Eversley Rest Home and Village that sets out the facility's business objectives; marketing status and competitor overview.</p> <p>The facility is managed by a BCM who is supported by a clinical manager (CM). The BCM is a registered nurse (RN) who has been employed at the facility as BCM for the last five years and has over 20 years' experience in a BCM role at Eversley and other facilities. The BCM has a diploma in business; a diploma in gerontology and has completed leadership training. The clinical care at the facility is overseen by the CM. The CM is an RN who has been in this role for three and a half years and has previous experience as a RN in oncology and hospice care. The management team is supported in their roles by the Oceania executive and regional teams. The BCM and CM have undertaken induction and orientation appropriate to their roles.</p> <p>The facility is certified to provide rest home and dementia care for up to 50 residents. This includes 33 rest home only beds and 17 dementia care beds. At the time of the audit occupancy included: 31 residents assessed as requiring rest home level of care and 15 residents assessed as requiring dementia level care. Included in these numbers are three residents under the mental health agreement: two assessed at rest home level care (one of whom is under 65 years of age); and one assessed at dementia level care. Current numbers also include one resident assessed at rest home level care under the respite care agreement. The facility has contracts with the DHB for the provision of rest home and dementia level care; mental health; day care and respite care.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is</p> | FA | <p>During a temporary absence of the BCM, the CM with the assistance of an experienced administrator 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.</p> <p>In the absence of the CM, an experienced RN with the support and help of the BCM and the regional</p> |

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| managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | | clinical and quality manager, ensures continuity of clinical services. |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>The facility utilises Oceania's documented quality and risk management framework that is available to staff to guide service delivery.</p> <p>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 made available to staff in hardcopy. Policy updates are also provided as a part of relevant in-service education. Staff sign to confirm that they have read the revised policy. Staff interviews confirmed that they are advised of new and updated policies.</p> <p>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 (refer to 3.5.1).</p> <p>There was evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data provided 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 signed off. There is communication with staff of any subsequent changes to procedures and practice through meetings.</p> <p>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 a staff meeting book for staff who were unable to attend a meeting.</p> <p>Residents and family have input into service improvements and are notified of updates through the facility's resident/family forums. Satisfaction surveys for residents and family are completed as part of the internal audit programme. The April and September 2018 resident surveys reviewed evidenced satisfaction with services provided and this was confirmed by resident and family interviews.</p> <p>The organisation has a risk management programme in place that records the management of risks in clinical, environment, human resource 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. Corrective actions arising out of health and safety audits are implemented and signed off in a timely manner. All staff, including contractors, receive a health and safety induction on commencement. Risk assessments are</p> |

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| | | <p>completed by the health and safety committee for all new equipment and products.</p> <p>The BCM is responsible for health and safety. Staff interviews confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly. Staff interviews confirm that hazard reporting is actively encouraged. 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.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>Policy and procedures reference essential notification reporting including 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 one event since the last audit requiring essential notification to the Ministry of Health relating to a pressure injury and two events relating to outbreaks notified to the Public Health Unit.</p> <p>Staff interviews confirmed that they were encouraged to recognise and report adverse events. 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.</p> <p>There is an implemented incident/accident reporting process and incident/accident reporting forms are available in the staff room. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on an incident/accident form which is signed off by the BCM. Incident/accident 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 progress notes and notification of the resident's nominated next of kin where appropriate.</p> <p>Corrective actions arising from incidents/accidents were implemented. Information gathered is regularly shared at monthly meetings with incidents/accidents graphed, trends analysed. Benchmarking of incident/accident data occurs with other Oceania facilities. Specific learnings and results from incident/accidents inform quality improvement processes and are shared at quality and health and safety and staff meetings.</p> |

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| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>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.</p> <p>Systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that require them.</p> <p>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.</p> <p>The organisation has implemented the Oceania documented role specific mandatory annual education and training modules. Staff files and education records evidenced that ongoing education is provided. Training records evidenced that staff have undertaken a minimum of eight hours of relevant training.</p> <p>Two of four RNs, including the CM, have completed interRAI assessment training and competencies. There is one RN on maternity leave at the time of audit who has also completed interRAI assessment training and competencies. Systems and processes are in place to ensure that all staff complete their required training and competencies. Annual competencies are completed by care staff and include, for example: medication management; hand washing; moving and handling; wound management; dementia and restraint.</p> <p>Five staff have successfully completed the four required dementia unit standards, one is awaiting the results of the final standard, and four are in the process of completing the third and/or fourth unit standards. Two staff are yet to commence dementia training, subject to satisfactory completion of a one month trial in the dementia unit.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>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.</p> <p>Rosters are available to staff 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 acuity and the number of residents.</p> <p>There are sufficient RNs and health care assistants (HCA), available to safely maintain the rosters for</p> |

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| | | <p>the provision of care, to accommodate increases in workloads and acuity of residents. The facility is spread over one level with the rest home rooms at one side of the facility and a secure dementia unit is at the opposing end.</p> <p>The rest home wing has 33 beds with 31 residents assessed at rest home level of care. There are two HCAs on duty on the morning for eight hours and one short shift to cover the morning peak time. There are two HCAs on duty for eight hours on the afternoon shift plus a third short shift at peak time. On night duty there are two HCAs.</p> <p>The dementia unit has 17 beds with 15 residents assessed at dementia level care. There are two HCA on duty on the morning for eight hours and one short shift to cover the morning peak time. There are two HCAs on duty for eight hours and one for six hours on the afternoon duty. On night duty there is one HCA.</p> <p>The BCM, who is a RN is on duty each week day morning. In addition to the CM, who is on duty in the morning shift from Tuesday to Friday, there is one RN on duty on each morning shift, seven days per week. Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract.</p> <p>There are 46 staff, including: the management team; administration; clinical staff; diversional therapist; and household staff. Household staff include cleaners who provide services seven day a week and kitchen staff. An RN is on call after hours.</p> <p>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 confirm that they have sufficient time to complete their scheduled tasks and resident cares.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>Residents' records are maintained in hardcopy and electronically. Residents' information, including progress notes, are legible and entered into the resident's record in an accurate and timely manner, identifying the name and designation of the person making the entry. Health care assistants update resident progress notes on each shift. However, there was insufficient evidence that the RN updated residents' progress notes on a regular basis or where ever there was any change of condition (refer to 1.3.3.3).</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of their obligations and the 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. Documentation containing sensitive resident information is not</p> |

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| | | <p>displayed in a way that could be viewed by other residents or members of the public.</p> <p>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.</p> <p>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.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>Needs Assessment and Service Coordination Service (NASC) assessments are completed for entry to this service. Residents are assessed as requiring rest home level of care or specialist dementia services. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements.</p> <p>There is an information pack provided to residents and their families. Written information on the service philosophy and practices particular to the dementia unit is provided to the family members of residents' with dementia.</p> <p>Interviews with residents and family and review of clinical records confirmed the admission process was completed by staff in a timely manner. Residents and family interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | FA | <p>Exit, discharge, or transfer is managed in a planned and coordinated manner.</p> <p>Interviews with RNs and review of resident files confirmed there is open communication between services, the resident, and the family. All relevant information is documented and communicated to the receiving health provider. A transfer form accompanies residents to receiving facilities.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p> | FA | <p>There are policies and processes that describe medication management that align with current legislation and safe practice guidelines. Medicines are delivered in a pre-packed delivery system and checked against the residents' medication profiles on arrival from the pharmacy. A computerised medication management system is used at the facility.</p> <p>Review of the medication areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The drug</p> |

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| guidelines. | | <p>register is maintained and evidenced weekly checks and six-monthly physical stocktakes.</p> <p>The medication round observed evidenced compliance with legislation and safe practice guidelines. All staff authorised to administer medicines had current competencies. Staff education in medicine management is provided.</p> <p>The medication refrigerator temperatures are monitored and recorded weekly and are within the recommended temperature range.</p> <p>Self-administration of medicine policies and procedures are in place. There were no residents self-administering medicines at the facility on the days of audit.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>All food is prepared onsite. The food service is in line with recognised nutritional guidelines for older people. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan. Food temperatures are monitored appropriately and recorded as part of the plan.</p> <p>The kitchen cleaning schedules and equipment is maintained. Kitchen staff complete an orientation and relevant food safety training. Food in the chiller was covered and dated. The kitchen was clean and all food was stored off the floor.</p> <p>There is a four weekly seasonal menu approved by a dietitian at organisational level. Diets are modified as required. At interview, the chef reported the RN completes each resident's nutritional profile on admission with the aid of the resident and family. The kitchen is made aware of any changes. Special diets are catered for and documented in the kitchen. Special equipment, to meet residents' nutritional needs, is readily available. The dementia unit is provided with additional snacks that are available over a 24 hour period.</p> <p>The service encourages residents to express their likes and dislikes. The residents interviewed stated that staff ask them about their food preferences and they complete surveys which include comments about the food service.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the</p> | FA | <p>When residents are declined access to the service, residents and their family, the referring agency and the general practitioner (GP) are informed of the decline to entry. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services. The resident would be declined entry if not within the scope of the service or if a bed was not available.</p> |

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| organisation, where appropriate. | | |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>The initial nursing assessment and the initial care plan is completed within 24 hours of admission. Assessments are recorded, reflecting data from a range of sources, including: the resident; family; GP, nurse practitioner; and specialists as applicable. Review of wound care documentation evidenced some wounds including skin tears are recorded on short-term care plans (refer to 1.3.8.3). Resident assessments inform the long-term care plans (refer to 1.3.3.3).</p> <p>Policies and protocols are in place to ensure continuity of service delivery. Assessment tools are reviewed at least six monthly including, but not limited to: dietary; continence; and pain. Residents interviewed confirmed assessments are conducted according to their needs and in a private manner.</p> <p>Review of the environment and interviews with staff confirmed adequate resources and equipment are available to meet the needs of residents. Interviews with residents and families confirmed their involvement in the assessments, care planning, review, treatment, and evaluation of residents' care.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | PA Moderate | <p>The initial care plans reviewed were not always fully completed to ensure all residents' needs were recorded for the first three weeks of the resident's admission. Long-term care plans are developed with the resident and/ or family/whānau involvement, where appropriate (refer to 1.3.3.3). Short-term care plans are developed for the management of some acute problems (refer to 1.3.8.3). All files sampled had an individualised long-term care plan that covered all areas of identified needs.</p> <p>The GPs and allied health staff document in the resident's file at each consultation.</p> <p>Interviews with residents and family confirmed they have input into their care planning and review, and that the care provided meets their needs.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>Review of residents' long term care plans evidenced detailed interventions based on assessed needs, desired outcomes, and goals of residents. General practitioner documentation and records were current. Interviews with residents and families confirmed that the current care and treatment needs were being met. The service maintains family communication records in the residents' files. Nursing progress notes and observation charts are maintained (refer to 1.3.3.3).</p> <p>There is evidence of referral to specialist services such as physiotherapy, nutritional, podiatry and specialist nurses where required.</p> <p>Staff interviews confirmed they are familiar with the needs of the residents they are allocated to.</p> |

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| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The facility provides an activities programme which reflects the residents' goals, ordinary patterns of life, and includes community activities. Review of the residents' clinical files evidenced residents' social history and their preferred activities are identified and recorded in the long-term care plan. The diversional therapist plans a monthly activities programme, which is made available to residents and their families.</p> <p>Residents are free to choose whether they wish to participate in the group activities. Residents' participation in the programme was evidenced on audit days. Rest home residents are encouraged to maintain links with the community. Birthdays and other special days are celebrated.</p> <p>Residents' attendance and participation at the activities is documented. Evaluations are completed six monthly with nursing review and there is evidence of resident and family participation (refer to 1.3.8.2). Resident meetings are conducted bi-monthly and include discussion around activities. The facility provides family forum meetings that are held every two months to provide information sharing and support for families.</p> <p>Residents have individual assessments to determine their individual diversional, motivational and recreational requirements and these are documented on the 24 hour activities plans.</p> <p>The residents and their families reported satisfaction with the activities provided.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | PA Moderate | <p>Resident care is evaluated on each shift and reported in the progress notes (refer to 1.3.3.3). When changes are noted it is reported to the RN, as confirmed at care staff interviews.</p> <p>Care plan evaluations occur every six months. The care plan evaluations did not consistently record the achievement of the residents' goals and the degree of achievement to the support/interventions provided.</p> <p>Short-term care plans were not always completed for short-term problems and evaluated when required.</p> <p>Interviews with residents and family confirmed they are included and kept up to date with any changes.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services</p> | FA | <p>The service facilitates access to other medical and non-medical services. If the need for non-urgent services are indicated or requested, the GP, RN, or CM send a referral to seek specialist service provider assistance from the DHB. Referral forms and documentation are maintained in residents'</p> |

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| <p>(Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | | <p>files. Referrals are followed up on a regular basis by RN, CM or the GP.</p> <p>The family/whānau communication records reviewed in the residents' files confirmed family are kept informed of the referral process.</p> <p>There is a multidisciplinary team approach evident in the resident files and progress notes record facilitation of choices to the residents (refer to 1.3.3.3).</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>Documented policies and procedures for the management of waste and hazardous substances are in place. The emergency and business continuity plan also includes the steps to take in the event of a hazardous substances spill. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling, disposal and collecting waste. The hazard register is available and current.</p> <p>Current material safety data posters are available and accessible to staff in relevant places in the facility for example the kitchen; sluice; and cleaning cupboard. Staff interview and records confirmed that staff receive training in the safe use of chemicals.</p> <p>Staff receive training and education in waste management and infection control as a component of the mandatory training.</p> <p>Interviews and observations confirmed the availability of sufficient personal protective clothing and equipment provided, such as aprons, gloves and masks. Observation and staff interviews confirmed that the use of personal protective clothing and equipment is appropriate to the recognised risks and was used in high-risk areas.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation.</p> <p>A preventative and reactive maintenance schedule is in place and implemented. This includes monthly maintenance checks of all areas and specified equipment such as wheel chairs for tyres and brakes; walkers; and the holding temperatures of fridges and freezers. Staff identify maintenance issues in a maintenance log book. These are reviewed three times per week by the maintenance person. Urgent requests are attended to as required. A review of maintenance requests and interviews confirmed staff awareness of the processes for maintenance requests and that repairs were conducted in a timely manner.</p> <p>Staff and resident interviews and visual inspection confirmed there is adequate equipment to support care, including care for residents with disabilities. An external contractor undertakes an annual test</p> |

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| | | <p>and tag programme and this is up to date. There is evidence of checking and calibration of biomedical equipment and other equipment such as appliances. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained.</p> <p>Hot water temperatures are assayed monthly. A review of temperature assays noted that these were maintained within recommended temperature ranges. An interview with the maintenance person confirmed that where hot water temperatures had been above the recommended safe temperature, action was taken and rechecking of the temperature occurred to ensure a safe temperature was maintained.</p> <p>The rest home area has four internal open air garden courtyards with shade. These are able to be accessed freely by residents and their visitors. The dementia unit has a secure external garden area. In addition, there are external grounds with grassed areas and park adjacent to the facility. All resident areas can be accessed with mobility aides. Observation and resident and family interviews confirmed that residents can move freely around the facility and that the accommodation meets their needs.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>There are sufficient numbers of accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility. There is one larger room with a full ensuite. There are some rooms that have a toilet and hand basin and some rooms that have access to shared toilet and bathroom facilities. There are two rooms that are shared by a couple with one room used as a bedroom and the second as their living room.</p> <p>Communal toilets have a system to indicate vacancy and have sufficient disability access. A visitor toilet is conveniently located near the entrance to the facility. All shower and toilet facilities have call bells; sufficient room for manoeuvrability of a resident and staff member; approved handrails; and other equipment to facilitate ease of mobility and independence.</p> <p>Residents were observed being supported to access communal showers in a manner that was respectful and preserved the resident's dignity.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group</p> | FA | <p>Residents have 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. Observation and resident interviews confirmed that there was sufficient space to accommodate: personal items; furniture; equipment; and staff as required.</p> <p>Residents and their family are able to personalise their rooms with their own furniture and furnishings. Furniture in residents' rooms includes residents' own personal pieces and memorabilia;</p> |

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| and setting. | | <p>is appropriate to the setting; and is arranged in a manner that enables residents to mobilise freely.</p> <p>Equipment such as wheel chairs, walking frames and a hoist were observed to be stored tidily in designated areas.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>The rest home has a main dining room and lounge area close to the kitchen. In addition, there is a separate smaller dining room and sitting room in the dementia unit and smaller sitting/lounge areas throughout the facility. All internal communal areas have seating and an external views. In addition, there are external areas with seating and shade. All areas can be easily accessed by residents and staff. Sufficient areas are available for residents to access with their visitors if they wish. These areas include a library/quiet room and places where residents could find privacy. Observation and residents and family interviews confirmed that residents can move freely around the facility and that the accommodation meets their needs.</p> <p>The main lounge area was observed to be used for activities.</p> <p>Residents were observed to have their main meal with other residents in communal dining rooms and can choose to have their meals in their room if they wish.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | FA | <p>Facility laundry, including residents' personal clothing, is completed off site by another facility. Where required, ironing of resident clothing is undertaken on-site by night duty HCAs. The facility has a washing machine that is infrequently used to launder resident laundry if required urgently. Colour coded, covered laundry trolleys and bags were observed to be used for transport. Household staff interviewed confirmed knowledge of their role including management of any infectious linen. Clean and dirty areas are clearly delineated and observed in the laundry area. Resident and family members stated that the laundry standard met their requirements.</p> <p>A cleaner is on duty each day, seven days a week and 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. Household staff have received training in the correct and safe use of chemicals. Cleaning equipment and chemicals are stored safely and hygienically in designated locked cupboards. The cleaner stores chemicals on a trolley when cleaning and is aware of the need to keep the trolley with them at all times. Resident and family interviews, resident surveys and observation noted the facility to be clean and tidy.</p> <p>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.</p> |

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| | | <p>The effectiveness of cleaning and laundry processes are monitored through the internal audit process. Where issues had previously been identified with regard to laundering, such as missing resident clothing, corrective actions had been generated, recommendations implemented and signed off.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | FA | <p>The facility has an emergency and business continuity plan includes guidance and resource for staff in the event of an emergency or disaster. It includes a variety of possible emergency events such as: fire; earthquake; flooding; hazardous substance spills; evacuation; robbery; challenging behaviour and a missing person. The plan identifies the contingency plans for all potential service failures and includes considerations of all levels of resident need.</p> <p>Staff files and training records demonstrate 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. A sprinkler system installed throughout the facility; and exit signage displayed. Training records demonstrate that twelve staff have completed fire warden training and the most senior staff member on site on each shift is the building fire warden.</p> <p>The staff competency register evidenced that 20 staff have current first aid certificate. This includes the BCM; CM; RNs; diversional therapist; and HCAs. There are at least two staff members on each shift with a current first aid certificate.</p> <p>Sufficient supplies are available to sustain staff and residents in an emergency situation. Alternative energy and utility sources in the event of the main supplies failing. These include but are not limited to a barbeque and gas bottles; torches and lanterns; emergency lighting; sufficient continence supplies; food and water.</p> <p>A call bell to summon assistance is operational in all resident rooms and bathrooms. Call bells and sensor mats are checked monthly for activation and visual display by the maintenance person. Observation on the days of the audit and resident and family interviews confirmed that call bells are answered promptly.</p> <p>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 and the facility being locked at 5 pm in the evenings with restricted entry, through ringing the doorbell afterhours. Staff complete security training as part of the mandatory annual training programme.</p> |

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| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All residents' rooms and communal areas accessed by residents have safe ventilation and sufficient external windows providing natural light. Heating in the winter is provided by water heated wall panel heaters in resident rooms and communal areas. A recently installed ducted air conditioning system provides cooling in summer months. Cooling in the summer months is also facilitated by closing blinds and double glazing in some rooms. The environment in all areas was noted to be maintained at a satisfactory temperature for residents and staff.</p> <p>Feedback on the comfort and temperature of the environment is obtained through the resident forums. 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.</p> <p>There is a designated 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 was one resident who smoked.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | PA Low | <p>The infection control policies and procedures manual for Oceania Healthcare is current and documents the infection control policy and the terms of reference for the infection control programme. The infection control nurse (ICN) is a RN and has access to external specialist advice from GPs, DHB infection control specialists, and microbiologists when required. A documented role description for the ICN, including role and responsibilities, is in place.</p> <p>The Oceania infection control committee (company-wide) is led by the Oceania general manager aged care. Infection control team at the facility reports to the BCM/CM who report to the regional clinical quality manager. The regional clinical quality manager reports serious infection control issues to the general manager aged care at the Oceania support office.</p> <p>The infection control programme has not been reviewed annually.</p> <p>Staff are made aware of new infections through daily handovers on each shift, progress notes and short-term care plans (refer to 1.3.8.3 and 1.3.3.3). There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use. Staff interviewed demonstrated an understanding of the infection prevention and control processes.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p> | FA | <p>The ICN is responsible for implementing the infection control programme at the facility. The ICN indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility meetings (refer to 3.5.1). The ICN</p> |

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| physical, and information resources to implement the infection control programme and meet the needs of the organisation. | | has access to all relevant resident data to undertake surveillance, internal audits, and investigations. |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | Oceania has documented policies and procedures in place that reflect current best practice relating to infection prevention and control. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and are able to locate policies and procedures. |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | Staff education on infection prevention and control is provided by the ICN, CM or external infection control specialists. Infection control education is a mandatory requirement for all staff. A record of attendance is maintained. External contact resources include GP; laboratories; and local DHB staff. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | PA Low | <p>The documented infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, analysed, monitored and reviewed monthly.</p> <p>Staff interviewed reported they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required timeframe when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, as confirmed at GP interviews.</p> <p>The ICN collects surveillance data, however, not all data relating to infections is collected. The CM enters the data onto the Oceania intranet. The Oceania support office conducts benchmarking in infection prevention and control with other Oceania facilities and this is shared with management and staff.</p> <p>The ICN interviewed confirmed there had been two outbreaks since the previous audit. There was</p> |

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| | | evidence this was reported to the required authority. |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>The definitions of restraint and enabler in the restraint minimisation and safe practice policy are congruent with the definitions in the standard. The approval process for enabler use would be activated when a resident voluntarily requests an enabler to assist them to maintain their independence and/or safety, as confirmed at staff and management interviews.</p> <p>The facility is restraint free. The restraint coordinator is the BCM. Staff and management interviews confirmed restraint has not been used at the facility for approximately four years. The dementia unit has appropriate environmental restraint required for dementia level of care services.</p> <p>Staff receive training including the required aspects of restraint and enabler use, alternatives to restraint and dealing with challenging behaviours. Staff demonstrated knowledge and understanding of the restraint and enabler processes.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | <p>PA</p> <p>Moderate</p> | <p>The GP initial medical examinations occur within the required timeframes of the residents' admissions to the facility. The clinical files of the residents evidenced the residents were examined by the GP three monthly. The residents' medical conditions were not recorded and signed by the GPs as stable, for this exception to indicate that the residents may be examined by a GP less frequently than monthly. This was evidenced in all seven residents' files reviewed. Interviews with management confirmed all residents are examined by the GPs three monthly unless their clinical condition requires more frequent review and that the GP exception are not recorded.</p> <p>The initial care plans are completed on the resident's admission to the facility (refer to 1.3.5.2). Additional assessments such as dietary and pain assessments are recorded. The clinical files evidenced three of seven interRAI assessments and long-term care plans were completed within the 21 days of the residents' admission to the facility.</p> | <p>i) The GP exceptions for three monthly medical reviews are not recorded in the residents' clinical files.</p> <p>ii) Initial interRAI assessments and long-term care plans were not always</p> | <p>i) Ensure GP exceptions are recorded for three monthly medical reviews.</p> <p>ii) Ensure all initial interRAI assessment and long-term care plans are completed</p> |

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| | | Residents' progress notes are maintained by HCAs on each shift. Progress notes did not always document timely review by the RNs. The Oceania progress notes policy records for rest home and dementia unit level residents for the RNs to update the progress notes at any change of condition and at least three times on a morning shift per week. There was evidence in the four of the seven clinical file that the RN input was not recorded at this frequency. | completed within 21 days of admission. iii) Progress notes do not always document timely review by the RNs as required by policy. | within required timeframes. iii) Ensure progress notes document timely review by the RN as required by policy. 90 days |
| Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The initial care plans are completed on the residents' admissions to the facility by the RNs or the CM. There was evidence in four of the seven clinical files reviewed of incomplete initial care plans. This included no entry in the initial care plans relating to interests and activities; spirituality; cultural care; sexuality and intimacy; and pain. There was evidence of a Māori resident's needs in the initial care plan not recorded for their spirituality and cultural needs. A resident experiencing chronic pain did not have their pain needs identified in the initial care plan. | Initial care plans are not consistently fully completed. | Ensure initial care plans are consistently fully completed. 90 days |
| Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Long-term care plan evaluations are completed six monthly. Review of the residents' clinical files evidenced two of the seven files did not record the achievement of the residents' goals and the degree of achievement to the support/interventions provided. Review of the wound management at the facility was conducted. Documentation for all wounds (16 in total at time of audit) were reviewed. Wound care plans do not always evidence evaluations are completed. There was evidence of wound care plans not recording the days of next wound reviews and wound not being evaluated according to scheduled evaluation dates when they were recorded. | i) Long-term care plan evaluations do not consistently record the achievement of residents' goals and the degree of achievement towards meeting those | i) Ensure long-term care plans are evaluated to indicate the degree of achievement and progress towards meeting the residents' desired |

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| | | | goals. ii) The wound care plans do not always record the required evaluation timeframes and when recorded these are not consistently adhered to. | goals. ii) Ensure wound care plans record the evaluation timeframes and these are adhered to. 90 days |
| Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | The Oceania policy records the requirement for simple wounds, such as 1A and 1B skin tears, to be managed and documented using the short-term care plans. Wound assessments and management plans are to be completed for all wounds that require more extended wound management. There was evidence of some short-term care plans recorded for short-term problems. Review of the wound management system at the facility evidenced there were two wounds that were not recorded on short-term care plans and one short-term care plan was commenced three days post the wound identification. | Short-term care plans are not consistently completed for short-term problems. | Ensure short-term care plans are completed for short-term problems. 90 days |
| Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | The Oceania Healthcare Limited documents infection control policies and procedures and these are current. The infection control programme is documented. Review of the infection control data and interviews with staff and management confirmed the infection control programme at the facility has not been reviewed annually. | The facility's infection control programme has not been reviewed annually. | Ensure the facility's infection control programme is reviewed annually. 180 days |

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| <p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p> | <p>PA Low</p> | <p>The infection control surveillance policy informs staff on the required collection and collation of the surveillance statistical data. The definitions of infections for surveillance are documented. The required surveillance of infections include potential infections and untreated infections. Interview with the ICN confirmed they collect infections at the end of each month via the electronic medication programme. This data captures infections that have been treated with antibiotics. Potential and untreated infections are not collected. Review of the surveillance logs for the month of February 2019 were not recorded as this data would be compiled towards the end of the month, as confirmed by the ICN.</p> | <p>Not all infections (potential and untreated) are captured in the surveillance data.</p> | <p>Ensure all infections are included in the infection control surveillance.</p> <p>180 days</p> |
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.