Oceania Care Company Limited - Redwood Retirement 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:

Legal entity:	Oceania Care Company Limited
Premises audited:	Redwood Rest Home and Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 February 2019 End date: 13 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: 59

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

Redwood Rest Home and Village is part of Oceania Healthcare Limited. The facility is certified to provide services for 84 residents. At the time of the audit beds were available for up to 69 residents requiring rest home or hospital level of care. There were 59 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 two areas identified at this audit as requiring improvement relating to long-term care plans and resident dietary assessments.

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.

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 Commissioner's office 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. 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 provides operational oversight of the service. The acting 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 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The organisation works with the Needs Assessment Coordination Service to ensure access to the service is efficient with all relevant information available, whenever there is a vacancy.

The residents' needs are assessed on admission by registered nurses. Residents' initial care plans completed within the required timeframes and short-term care plans for acute conditions are in place where applicable. The residents' files provided evidence of documented residents' needs, goals and outcomes that are reviewed on a regular basis.

Nursing care plan evaluations are documented, resident-focused and indicate progress towards meeting the residents' desired outcomes. There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and a family member interviewed reported being informed and involved, and their satisfaction with services.

The activities programme includes a range of activities and involvement with wider community. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

There is a medicine management system in place which complies with legislation, protocols, and guidelines. Staff responsible for medicine management have current medication competencies. The residents self-administering medicines do so according to policy.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. There is a central kitchen and on-site staff that provide the food service. The 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. 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.

Restraint minimisation and safe practice policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use.

There was one resident using restraint and eight residents requesting the use of enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour has been provided.

Infection prevention and control

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

The infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection and cross infection and contain all requirements of the standard. The service provides an environment which minimises the risk of infection to residents, staff and visitors.

The infection prevention and control programme is reviewed annually. New staff are provided with training and orientation in infection control practices and there is ongoing infection control education available for all staff. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirmed that the surveillance programme is appropriate for the size and complexity of the services provided. The results of surveillance are reported through all levels of the organisation, including governance.

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	48	0	1	1	0	0
Criteria	0	99	0	1	1	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 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, 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. 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 interviews confirmed that they receive information relevant to their needs.
Standard 1.1.10: Informed Consent Consumers and where appropriate	FA	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 in order that

their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.		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. The information pack provided on/prior to admission includes information regarding informed consent. 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. 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.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There is an advocacy policy and procedure for staff to follow 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 prior to or on their admission to the facility. Additional advocacy services brochures are also available at the entrance to the residents' dining room. The complaints policy also includes making residents aware of their right to advocacy when making a complaint. Interview with the BCM confirmed that advocacy services can also be accessed on behalf of residents externally through Age Concern and the Nationwide Health and Disability Advocacy Service if required. A local advocate visits the facility once a week to play the piano and meet with residents and families. Family and resident interviews confirmed that the facility provides opportunities for the family to be involved in decisions, they are aware of the right to advocacy and the advocacy services available.
Standard 1.1.12: Links With	FA	Observations and resident and staff interviews confirmed that residents may have access to visitors

Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.		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 are 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 church and social activities and family outings. The activities programme and the content of care plans include regular outings in the community. Staff stated that residents under the YPD contract and those under 65 years of age are supported and encouraged to access activities and resources in the community as well as family and networks if they so choose.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisation's complaints policy 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. 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. Interview with the BCM and a review of complaints indicated that complaints are investigated promptly and issues are resolved in a timely manner. Staff interviews confirmed that residents and family are encouraged to raise any concerns and provide feedback on services and this includes reminding them of the complaints process. Residents and family interviews confirmed that they are 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. There has been one complaint to the Health and Disability Commissioner since the previous audit relating to resident care. The organisation has provided the information requested and is awaiting the outcome of the investigation.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their	FA	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

rights.		information on the complaints process and advocacy service. The Code and associated information are also available in information brochures which are displayed throughout 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 at the entrance to the facility.
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. Resident, staff and family interviews and observation confirmed that staff knock on bedroom and bathroom doors prior to entering rooms, ensure that doors were shut when personal cares were being provided and residents were suitably attired when taken to bathrooms. 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. 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. Residents confirmed that they choose their own clothing to wear each day. Residents were observed to be wearing makeup and personal adornments of choice. Resident files, staff, resident and family interviews and satisfaction surveys confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented, and upheld for all residents including younger persons with disabilities (YPD). 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.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs	FA	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

met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		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 a local Māori provider. Staff receive training in cultural safety and values at orientation and as well as part of the mandatory annual education programme. There was one resident 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. This includes making available a private room, with facilities for relaxing, sleeping and tea and coffee facilities, to family members wishing to be close to an unwell or dying resident.
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 assessment and 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 a chosen spiritual advisor or counsellor. An interdenominational church service is held at the facility every two weeks for residents who chose to attend a service. Alternatively, residents are able to attend their chosen service in the community. Some residents are also visited on a regular basis by their local pastor. 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 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 their obligation to report any evidence of discrimination, abuse and neglect, harassment and exploitation.

		There were no documented 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. The facility enters data 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. 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 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. Family and resident interviews confirmed that family are included in resident care planning meetings. Two to three monthly residents' meetings inform residents of facility activities. Meetings are advertised on the resident notice board. Interviews with the BCM and residents advised that residents are also reminded individually close to the meeting time of the upcoming meeting. Family are welcome to attend upcoming 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: survey results; feedback on the kitchen; entertainers; activities; and the upcoming facility audit. Copies of the activities plan and the menu are also available to residents. Residents and family interviews confirmed that they felt comfortable in approaching the BCM and acting clinical manager (ACM) to discuss services and issues. Residents/family stated they were

		confident that concerns raised and queries were addressed promptly. 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. Interview of the BCM confirmed that interpreter services would be accessed through a local cultural organisation or language line 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 needs of consumers.	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. In addition to the overarching Oceania business plan, the facility has a current 2018-2020 business plan specific to Redwood Rest Home and Village that sets out the facility's business objectives; marketing status and competitor overview. The facility is managed by a BCM who is supported by an ACM. The BCM has been employed at the facility as BCM for the last three months. The BCM has previous experience in marketing and banking management roles. The BCM has undertaken an induction and orientation appropriate to the role. The clinical care at the facility is overseen by the ACM. The ACM is a registered nurse (RN) at the facility who was appointed to the ACM role two months prior to the audit and has 30 years' experience as a registered nurse (RN), including previous experience as ACM at this facility. The management team is supported in their roles by the Oceania executive and regional teams. This support includes a relieving BCM who has spent one week each fortnight at the facility providing mentoring and guidance for the new BCM. The regional clinical quality manager has been visiting the facility regularly to provide clinical support since the departure of the previous clinical manager in December. In addition, as support for the ACM, a relieving clinical manager commenced at the facility on the second day of the audit, who will work two to three days a week for one month or until the recruitment process for a clinical manager is completed. The facility is certified to provide rest home and hospital level care for up to 84 residents. This includes 48 rest home only beds, 23 hospital beds and 13 occupation right agreement (ORA) dual

		purpose suites (care suites). At the time of the audit, a number of resident rooms were being used for administrative functions or being refurbished and consequently the facility currently has 69 available beds. There were 59 beds occupied at the time of the audit. Occupancy included 41 residents assessed as requiring rest home level of care and 18 residents assessed as requiring hospital level. These numbers included two YPD requiring hospital level of care. Also included in total occupancy numbers were two residents assessed at rest home level care and one at hospital level care under the respite care agreement. The facility has contracts with the district health board (DHB) for the provision of rest home and hospital level care, YPD and respite care.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During a temporary absence of the BCM, the Oceania relieving CM would be responsible for the day to day operation of the service until the vacant CM role is appointed and established. The relieving CM is supported by experienced RNs, the regional clinical and quality manager, and the regional operations manager. In the absence of the ACM, a relieving CM with the support and help of RNs and the regional clinical and quality manager will ensure continuity of clinical services.
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 Sector 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 on the staff noticeboard. Policy updates are also provided as a part of relevant in-service education. Staff confirmed that they are advised of new and updated policies. The 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 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 and staff notices. 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. Staff sign to confirm attendance at the meeting or if not present to confirm that they had read the meeting minutes. Residents, including YPD, and family are notified of updates through the facility's resident meetings. Satisfaction surveys for residents and family are completed as part of the internal audit programme. The October 2018 surveys reviewed evidenced satisfaction with services provided and this was confirmed by resident and family interviews. Resident interview confirmed YPD are satisfied with the services and equipment provided and have input and choice in regard to services, aids, and equipment provided to them. 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. 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 been in the role for three years. Interview confirmed an understanding of the obligations of the role. Staff interviews confirmed that hazard reporting is actively encouraged. There was 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 has been one event since the last audit requiring essential notification to the Ministry of Health relating to a pressure injury. Staff interviews confirmed that all staff are 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/accident reporting process. There is an implemented incident/accident reporting process and incident/accident reporting forms

		are available throughout the facility. 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. Corrective actions arising from incidents/accidents were implemented. Information gathered is regularly shared at monthly meetings with incidents/accidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Results of incident/accident data is benchmarked nationally with other Oceania facilities and trends are analysed. Specific learnings and results from incidents/accidents 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 that require them. 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. Training records evidenced that staff have undertaken a minimum of eight hours of relevant training. Five of seven RNs have completed interRAI assessments training and competencies. There are systems and processes in place to ensure that all staff complete their required training and competencies. Annual competencies are completed by care staff include, for example: fire training; infection control; hoist use; restraint; medication management; and wound management.

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 two to four 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. 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 two rest home wings; one hospital wing and a care suite wing. There are 12 beds in the care suite wing with 11 residents assessed at rest home level of care. The nurses' station in the hospital wing is close to the care suites. There is one enrolled nurse (EN) or health care assistant (HCA) on duty on the morning shift for the care suites. The care suites are covered by staff in the hospital wing on afternoon and night shift. There is one care suite in the hospital wing, with a resident assessed at rest home level of care. In addition to the ACM, who is on duty in the morning shift Monday to Friday, there are two RNs on duty on the morning and afternoon shift and one on the night shift seven days per week. Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract. There are 61 staff, including: the management team; administration; clinical staff; activities assistant; and household staff. Household staff include cleaners who provide services seven day a week and kitchen staff. A review of rosters demonstrated that there is at least one RN on each shift. The BCM and ACM are on call after hours. Observation of service delivery confirmed that residents' needs were being met in a timely manner. Residents and family interviewed stated that staffing is adequate to meet the residents' needs. Staff confirmed that they have sufficient time to complete their scheduled tasks and resident cares.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents' records are maintained in hardcopy, with electronic medication charts in use. 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. Residents' progress notes are completed every shift, detailing resident response to service provision. 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. 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 and the assessment processes are recorded and implemented. The organisation works with the Needs Assessment and Coordination Service (NASC), to ensure access to the service is appropriate and efficiently managed. Each potential resident who may be admitted to the facility is assessed using the interRAI home care assessment tool in the six months before the date of their admission, as confirmed by the data provided. The needs assessments are completed for rest home and hospital levels of care. The organisation obtains information from the NASC service and/or the general practitioner (GP) for residents accessing respite care. The facility information pack is available for residents and their family and contains all relevant information. The residents' admission agreements evidence resident and/or family and facility representative sign off. In interviews, residents and family confirmed the admission process was completed by staff in a timely manner, relevant admission information was provided and a discussion held with staff in respect of resident care conducted.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The resident's exit, discharge or transfer is managed in a planned and coordinated manner. There is appropriate communication between families and other providers, that demonstrate transition, exit, discharge or transfer plans are communicated, when required. At the time of transition, appropriate information is supplied to the person/facility responsible for the ongoing management of the resident.

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	There is a computerised medication system in place with appropriate processes implemented for the system to comply with current legislation requirements and safe practice guidelines. The medication areas evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The drug register is maintained and evidenced weekly checks and six monthly physical stock takes. Regular records of temperature checks for the medicine fridge have readings documenting temperatures within the recommended range. All staff authorised to administer medicines have current competencies. A medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures. The residents self-administering medicines at the facility do so according to policy. Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for analysis of any medication errors, and compliance with this process is verified.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low	There is a seasonal four week cycle menu provided, that is in line with recognised nutritional guidelines for older people, as verified by a dietitian's assessment of the menu. The service operates with a multi-site approved food control plan applicable to all Oceania facilities. Food temperatures are monitored and recorded as part of the food control plan. The food service staff have undertaken a safe food handling qualification and completed relevant food handling training. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The dietary profiles located in the residents' files reviewed were signed by the chef, to indicate their awareness of the residents' dietary requirements, however, there was evidence not all residents' dietary profiles were in the main kitchen or the satellite kitchen to guide kitchen and care staff when serving food to residents. Special equipment, to meet residents' nutritional needs, was sighted. The residents' files demonstrated monthly monitoring of individual resident's weight. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. Evidence of resident satisfaction with meals is verified by residents' and family interviews, sighted

		satisfaction surveys and residents' meeting minutes.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is a process to inform residents and their family, in an appropriate manner, of the reasons why the service had been declined and this would be implemented, if required. 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 residents would be declined entry if not within the scope of the service or if a bed was not available, as confirmed at management interviews.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The residents' needs are assessed on admission to establish an initial care plan. The residents have their needs identified through a variety of information sources that include, but are not limited to, the NASC interRAI home care assessments; GPs; specialists; other service providers involved with the resident; the resident; family and on-site assessments using a range of assessment tools. The residents' files evidenced residents' completed discharge/transfer information from the DHB, where required. The clinical files reviewed evidenced not all residents had interRAI assessments and the long-term care plans completed within 21 days of their admission (refer to 1.3.3.3). The files reviewed evidenced the residents had current interRAI assessments completed by trained interRAI assessors on site. There was evidence the results of the interRAI assessments were discussed with the residents and where appropriate the family. Residents' assessments are conducted in a safe and appropriate setting, including visits from the GP and specialists. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment findings in consultation with the resident and/or family, inform the care plan and describe the required support and interventions. Each resident has a long-term nursing care plan based on assessments carried out using an interRAI assessment tool (refer to 1.3.3.3). The residents', including YPDs', care plans are individualised, integrated and up to date. The care plan interventions reflect the risk assessments and the level of care required. Short-term care plans are developed, when required and signed off by the RN when short-term problems are resolved. In interviews, staff reported they receive adequate information for continuity of residents' care. The

		residents have input into their care planning and review. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interview. Care plans evidenced service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The documentation, observations and interviews verified the provision of care provided to residents was consistent with the residents' needs and their desired outcomes. The residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents (refer to 1.3.3.3). The GP documentation and records were current. In interviews, residents and family confirmed that the resident's current care and treatments meet the resident's needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the residents they were allocated. The facility has appropriate resources and equipment, as confirmed at staff interviews and through visual observation. The equipment available complied with best practice guidelines and met the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The residents are assessed to ascertain their social needs and appropriate activity and social requirements. The residents' activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matched the skills, likes, dislikes and interests evidenced in the residents' assessment data and is provided Monday to Friday. In interview, the activities coordinator confirmed the activities programme meets the needs of the service group and the service has appropriate equipment. The activities programme is evaluated by a diversional therapist. Regular exercises and outings are provided for those residents able to partake. The activities programmes include input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. There were current, individualised activities care plans in residents' files reviewed. Review of the two residents under the YPD contract evidenced their individual activities goals were documented and

		specific activities interventions match their goals. The residents' activity needs are evaluated regularly, as part of the formal six monthly care plan review. The residents' activities attendance records are maintained and activities progress notes are recorded monthly by the activities coordinator. Family/whānau and friends are welcome to attend all activities. The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programme. The residents' meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Timeframes in relation to care planning evaluations are documented and implemented. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals are carried out by the RNs and documented on the care plan evaluation form. Reassessments are completed using the interRAI assessments, every six months or when changes in resident's health status occurs. Residents with health status changes had completed reassessments using interRAI. There was evidence of resident, family, HCA, activity coordinator and GP input into care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews. The residents' care plans were up to date and reviewed six monthly. The residents' progress notes are entered on each shift and there is evidence residents' care is evaluated and reported on. If any change is noted it is reported to the RN. When resident's progress is different than expected, the RN contacts the GP, as required, confirmed at the GP interview. Short-term care plans are used when required. A short-term care plan is initiated for short-term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short-term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family are included and informed of all changes. The family are notified of any changes in resident's condition, as confirmed at family interviews.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or	FA	Appropriate processes and supports are in place to provide choices for residents in accessing or referring to other health and/or disability services. Family communication sheets confirmed family involvement. An effective multidisciplinary team approach is maintained and progress notes evidenced relevant processes are implemented.

referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		When required, referrals to non-urgent services are conducted by the GP or the RN. Referrals are documented in the residents' clinical files. Copies of referrals were sighted in residents' files reviewed including radiology; wound care specialist; mental health services for older persons and other health professionals. Referrals are followed up on a regular basis by the GP or the RN. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. The GP interview confirmed they are informed of any acute changes in resident's condition and involved in acute referrals to DHB.
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 collecting 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 for example the kitchen; laundry; sluice; and cleaning cupboard. The product supplier provides training in the safe use of chemicals. Staff receive training and education in waste management and infection control as a component of the mandatory training. 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.
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 in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation. A preventative and reactive maintenance schedule is implemented. This includes monthly maintenance checks of all areas and specified equipment such as hoists. Staff identify maintenance issues in a maintenance log book. These are reviewed every two days 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.

		Staff and resident interviews and visual inspection confirmed there is adequate equipment available to support care, including care for residents with disabilities and YPD. Resident interview and observation confirmed that personal equipment is available for YPD for their own use and that this not used for other residents. The facility has an annual test and tag programme and this is up to date. Evidence of checking and calibration of biomedical equipment and other equipment such as the dishwasher was sighted. A system ensures that the facility van that is used for residents' outings is routinely maintained. Van safety checks are undertaken and include for example: tyres; oil; hoist; and first aid kit. Inspection confirmed the van has a current registration, warrant of fitness, extinguisher and functioning hoist. Documentation evidenced that those staff who drive the van are assessed for competency. Hot water temperatures are assayed monthly and are maintained within recommended temperature ranges. A review of temperature assays and an interview with the maintenance person confirmed that where there have been hot water temperatures 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. External courtyards; grassed areas; and outdoor seating and shade are able to be accessed freely by residents and their visitors. Observation and resident and family interviews confirmed that residents, including YPD, 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	Sufficient numbers of accessible toilets and showering facilities of appropriate design to meet resident needs are located in each area of the facility. There is a mix of rooms with a full ensuite such as the care suites; rooms with their own toilet only, rooms that share a toilet and rooms that have access shared toilet and bathroom facilities. 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; approved handrails; and other equipment to facilitate ease of mobility and independence. Residents were observed being supported to access communal showers in a manner that was respectful and preserved the resident's dignity.
Standard 1.4.4: Personal Space/Bed Areas	FA	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. Resident interviews

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		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 residents' own furniture. Furniture in residents' rooms include residents' own personal pieces and memorabilia; is appropriate to the setting; and is arranged in a manner that enables residents to mobilise freely There are designated areas to store equipment such as wheel chairs, walking frames, commodes and hoists tidily.
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 dining room in one wing of the facility, adjoining the kitchen. In addition, a small dining room is situated between the care suites. There are three sitting rooms/lounges; a library; and a conservatory throughout the facility. All internal communal areas have seating and an external views. In addition, external areas provide seating and shade. Some rooms that have ranch sliders with access to external areas. All areas can be easily accessed by residents and staff. Sufficient areas are available for residents to access with their visitors if they wish. This include places where YPD 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 equipment and resources. A lounge area is used for main activities. Residents were observed to have their meals with other residents in communal dining rooms, however, they 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 off site by another facility. 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. There is clear delineation and observation of clean and dirty areas in the laundry area. Residents and family members stated that the laundry standard met their requirements. 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. 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.

		A sluice room, situated close to the laundry, is 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 with no significant problems identified. Resident and family interviews, resident surveys 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 sprinkler system installed throughout the facility; and exit signage displayed. Training records demonstrated that staff have undertaken fire warden training. There is an overall building fire warden and a nominated fire warden on each shift for each area. The staff competency register evidenced that staff have current first aid certificates where required. This includes: 5 RNs; 1 enrolled nurse; 2 HCAs; 1 household staff member; the cook; and the maintenance person. There is at least one staff member on each shift with a current first aid certificate. Sufficient supplies to sustain staff and residents in an emergency. Alternative energy and utility sources are available in the event of the main supplies failing. These include: LPG cylinders; two barbeques and gas bottles; emergency lighting; sufficient food, water, and continence supplies. The service's emergency plan includes considerations of all levels of resident need, including YPD residents. Call bells are available to summon assistance in all resident rooms and bathrooms. Call bells 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. Security systems are 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 6 pm in the evenings with restricted entry, through ringing the doorbell afterhours. Staff receive training in security as part of the annual training programme.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with	FA	All residents' rooms and communal areas accessed by residents have safe ventilation and sufficient external windows providing natural light. The facility is heated by underfloor heating in the care suites and hospital and part of the rest home. Other areas are heated by wall panel heaters. Some areas had reverse cycle heating and air cooling systems (heat pumps). Fans and open doors

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		provided cooling over summer. The environment in all areas was noted to be maintained at a satisfactory temperature for residents. Systems are in place to obtain feedback on the comfort and temperature of the environment. 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. A designated shaded external smoking area for residents is available and steps are in place to ensure that smoking does not impact on other residents or staff. At the time of the audit there were three 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 facility's environment minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The infection control nurse (ICN) has access to external specialist advice from Oceania senior management; GPs and DHB infection control specialists when required. A documented job description for the ICN, including role and responsibilities, is in place. The infection control programme is reviewed annually. Infection prevention and control is incorporated in facility's meetings. Staff are made aware of new infections through daily handovers on each shift and residents' progress notes. There are processes in place to isolate infectious residents when this is required. Hand sanitisers and gels are available throughout the facility for staff, residents and visitors to use.
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 is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. The ICN has allocated time to implement the infection control programme within the organisation. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of	FA	The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	New staff are required to undertake orientation that includes infection prevention and control, as evidenced in review of staff files. Staff education on infection prevention and control is conducted by ICN and external specialists. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. The ICN attended external infection control education in 2018.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The ICN maintains infection logs for residents' infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short-term care plans in place. The GP is informed in a timely manner when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively. Monthly surveillance analysis is completed and reported at monthly staff meetings and entered in the clinical indicators on the Oceania intranet. This information is reviewed by the Oceania clinical quality team and reported to the Oceania board on a monthly basis. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files. In interviews, the ICN and management confirmed there was an outbreak at the facility in 2018. There was evidence this was reported to the required authorities and managed according to the Oceania outbreak management process.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint minimisation and safe practice policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the ACM who demonstrated knowledge of the organisation's policies, procedures and practices relating to restraint and enabler use.

		On the days of the audit there was one resident using restraint and eight residents requesting the use enablers. Clinical staff interviews confirmed enablers are used voluntarily at a resident's request. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the meeting minutes of the restraint approval group, review of the restraint register and interviews with clinical staff and management.
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 coordinator is supported by the Oceania national and regional management team regarding restraint practice and quality and risk considerations. The role of the restraint coordinator is documented in their position description. The use of restraints is provided in monthly reports to the operational management team. The restraint use is approved by the clinical team, including the family and the GP. The approval process requires a full assessment of risk and evidence of trialled alternatives. The Oceania management team approves equipment which can be used as restraint within the Oceania facilities.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The restraint assessment process is documented and includes the requirements of this standard. Review of the clinical records of the resident using restraint on the days of audit confirmed completed assessment and compliance with the approval process. The assessment identified, for example, the cause, alternatives, risk, cultural considerations and outcomes.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	All restraints are used as a last resort, as confirmed at staff and management interviews. Discussions regarding trialled alternatives were sighted in the clinical record sampled. Once in place, restraints are monitored for safety. The restraint coordinator maintains a log of all restraint use. There have been no reported incidents related to unsafe restraint use. The restraint used was observed to be in safe use during the audit.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is evaluated every two months and during the care plan review process. Monitoring forms evidenced the restraint use was being monitored when required. Staff interviews confirmed their awareness of the importance of restraint monitoring.

Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint reports for the month are collated and reported to Oceania operational management team. These reports include trends and any adverse/untoward events. Compliance with the restraint policy and procedure is monitored. Oceania national restraint authority group conduct annual quality reviews of all restraints used nationally.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Low	The residents' dietary requirements are assessed on admission and reviewed on a regular basis. There are current copies of the residents' dietary profiles in the residents’ clinical files reviewed. The folder with individualised residents’ dietary requirements evidenced current residents’ dietary profiles were not always located or have been updated in the folder. The residents’ dietary requirements summary was not current in the kitchen and not located in the hospital servery. Interview with the chef indicated there were no residents who had food allergies at the facility. Upon review of the residents’ dietary needs there was evidence of four residents with food allergies. Discussion was held with management and corrective action was taken on the days of audit to place all current residents’ dietary profiles in the kitchen folder and document current residents’ food allergies, likes and dislikes and special requirements on a summary sheet for staff to refer to when serving food.	Residents’ dietary assessments, food allergies, likes and dislikes were not current within the kitchen and servery environments.	Ensure residents dietary requirements are located in the kitchen and serving areas for staff to refer to and adhere to when serving food. 90 days

Criterion 1.3.3.3 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.	PA Moderate	Home care assessments using the interRAI home care assessment tool are completed prior to the residents' admission to the facility. Review of the residents' clinical files evidenced the initial care plans are completed within the required timeframes. The interRAI assessments required to be completed within the 21 days post residents' admissions are not consistently completed. Four of the eight residents' files did not have interRAI assessments completed within the 21 day timeframe. Six of the eight residents' files reviewed evidenced long-term care plans were not completed within 21 days post admission as required.	InterRAI assessments and the long-term care plans are not always completed within the required 21 days post residents' admissions to the facility.	Provide evidence the timeframes relating to interRAI assessments and long-term care plans are adhered to. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.