

Oceania Care Company Limited - Wharerangi

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Oceania Care Company Limited

Premises audited: Wharerangi

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 10 September 2019 End date: 11 September 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: 42

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

| Indicator | Description | Definition |
|-----------|---|--|
| | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
| | No short falls | Standards applicable to this service fully attained |
| | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |

| Indicator | Description | Definition |
|-----------|--|---|
| | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
| | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

General overview of the audit

Wharerangi can provide care for up to 47 residents requiring rest home, hospital and dementia levels of care. There were 42 residents at the facility on the first day of the audit.

This surveillance audit was conducted against the relevant Health and Disability Services Standards and the service contract with the district health board.

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

There were no areas requiring improvement at the last certification audit.

There was one area identified as requiring improvement at this surveillance audit relating to staff training.

Consumer rights

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

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is provided to residents on admission and available within the facility.

Staff communicate with residents and family members following any incident and this is recorded in the residents' files.

Residents, family and nurse practitioner interviews confirmed that the environment is conducive to communication, including identification of any issues, and that staff are respectful of residents' needs.

There is a documented and implemented complaints management system. The business and care manager is responsible for managing complaints. There have been no complaints to external agencies 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. | | Some standards applicable to this service partially attained and of low risk. |
|---|--|---|

Oceania Healthcare Limited is the governing body responsible for the services provided at Wharerangi.

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement at the facility. Policies are reviewed, current and align with good practice, legislation and guidelines. Reports to the national support office allow for the monthly monitoring of service delivery.

Quality and risk performance is monitored through the organisation's reporting systems. An internal audit programme is implemented. Corrective action plans are documented with evidence of the resolution of issues when these are identified.

The facility is managed by an appropriately qualified and experienced business and care manager who is supported by a clinical manager. The clinical manager is responsible for the oversight of clinical service provision. The facility management team is supported by the regional clinical quality manager and the regional operations manager.

Oceania Healthcare Limited human resource policies and procedures are documented and implemented by Wharerangi. Newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff and contractors who require them, are validated annually.

Staffing levels within the facility are sufficient to meet the needs of residents' acuity levels.

Continuum of service delivery

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

Residents receive services from suitably qualified and experienced staff. The residents' files reviewed demonstrated the initial care plans were conducted within the required timeframes. InterRAI assessments are completed six-monthly. The long-term care plans are reviewed every six months and updated with changes as required. Short term care plans are evidenced for acute problems. Interviews confirmed residents and their families are informed, involved in care planning and the evaluation of care. A general practitioner or nurse practitioner reviews residents at least monthly unless the resident's condition is documented as stable. Handovers and progress notes confirm continuity of care.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Activities are planned and the activities programme includes a range of activities including involvement with the wider community.

The medicines management system is documented and implemented to provide safe processes for prescribing, administration, medication reconciliation, dispensing, storage and disposal of medicines. Medications are administered by registered nurses and health care assistants. Staff responsible for medicines management complete annual medication competencies.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines. There is a central kitchen and on-site staff that provide the food service. The kitchen staff have completed food safety training.

Safe and appropriate environment

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

A current building warrant of fitness is displayed. There had not been any alterations to the building since the last audit.

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 policies and procedures are in place. Restraint minimisation is overseen by a registered nurse. Staff receive training in restraint minimisation and challenging behaviour management. On the days of the on-site audit, the service had no restraint or enablers in use. Interviews with staff confirmed enablers are voluntary.

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 type of infection surveillance is appropriate to the size and complexity of the service. A registered nurse is the infection control nurse. Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Oceania Healthcare Limited support office. Review of surveillance records evidenced infection rates are monitored and infections are followed up when required. There have been no outbreaks since previous audit.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 15 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 38 | 0 | 1 | 0 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

| Standard with desired outcome | Attainment Rating | Audit Evidence |
|---|-------------------|--|
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld. | FA | <p>There are clear processes, policy and assigned responsibility to the BCM to manage complaints at the facility. The policy and processes align with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>A complaints register is in place and evidenced the complaints lodged document: the date the complaint was received; the category and a summary of the complaint; contact with the complainant; if the complaint required an investigation or a review; and the date the complaint was closed/resolved. Records relating to each lodged complaint are held in the complaint folder with the register. The complaints reviewed indicated that complaints are investigated promptly, and issues are resolved in a timely manner.</p> <p>Resident and family interviews confirmed that they were aware of opportunities and processes to raise any concerns and provide feedback on services and that they felt comfortable raising concerns directly with the BCM if they needed to. They stated that they were satisfied with how any issues raised had been dealt with.</p> <p>Residents and family interviews confirmed an understanding of their rights to advocacy and how to access advocacy services particularly in relation to the complaints process.</p> <p>There have been no complaints lodged with an external agency since the previous audit.</p> |

| | | |
|---|----|---|
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents and family are provided with an information pack on admission to the facility that documents all relevant information about their admission and residing at the facility. Additional information is provided for families of residents who are admitted to the dementia unit.</p> <p>There is a documented and implemented open disclosure policy. Open disclosure is conducted to ensure residents and family are informed of adverse events. Completed incident forms and residents' records reviewed demonstrated that family are informed if the resident has an incident/accident; a change in health or change in needs. Family and resident interviews confirmed that family are informed of any changes in resident's health status.</p> <p>Resident and family meetings inform residents and family of the facility's events and activities and provide an opportunity for suggestions; feedback; and to raise and discuss any issues or concerns with management. Minutes from the residents' meetings showed evidence that a range of subjects are discussed and issues raised. Communication and information is also provided to residents and family via monthly newsletters.</p> <p>Resident and family stated that they felt comfortable approaching the business and care manager (BCM) and the clinical manager (CM) with any issues/concerns they may have.</p> <p>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. Interviews confirmed when the interpreter service were required, they were accessed through local sources. At the time of the audit there were no residents for whom English was not their first language.</p> |
| <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>Wharerangi is part of Oceania Healthcare Limited (Oceania). Oceania has a documented mission, vision and values statements that are communicated to residents, family, staff and external agencies. Oceania has an overarching business plan and Wharerangi has a business plan specific to the facility.</p> <p>Communication between the facility and the Oceania support office team occurs on a monthly basis.</p> <p>The Oceania regional clinical and quality manager (CQM) provided support to the management team during this audit. Electronic reporting of facility's events, occupancy and progress against identified indicators are completed by the BCM monthly.</p> <p>The BCM has been in this role for five years and has been employed by Oceania for a total of eleven years. Previous positions held by prior to the BCM role included administrative roles. The BCM has a qualification in management, which was completed in 2012. The BCM is supported by a clinical manager (CM). The CM has been in the role for six years and has six years previous experience as a registered nurse at differing aged care facilities. The CM holds a current annual practising certificate and is supported by the Oceania CQM. Both the BCM and the CM have undertaken Oceania training and education relevant to their positions.</p> |

| | | |
|---|----|---|
| | | <p>The facility can provide services for up to 47 residents at rest home, hospital and dementia levels of care, with 42 beds occupied at the time of the audit. Occupancy included: 21 residents requiring rest home level care, 14 residents requiring hospital level care and 7 residents in the dementia unit. The facility holds contracts with the district health board (DHB) for: respite care; GP beds; day programme and chronic long-term care conditions. There were no residents under these contracts at the facility on audit days.</p> <p>The facility does not have any occupational right agreements.</p> |
| <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>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 policy updates are also provided as part of relevant in-service education. Staff sign to confirm that they have read and understand each new policy and/or update.</p> <p>Interviews confirmed that residents and family are satisfied with the services at the facility and that the service meets the residents' individual needs.</p> <p>Service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators such as: falls; infections; medication errors; restraint; sentinel events; weight loss; wounds. Clinical indicators are collated monthly and benchmarked against other Oceania facilities.</p> <p>The internal audit programme is documented and implemented as scheduled. Internal audits cover all services within the facility and evidence the audit data is collected, collated and analysed. Where improvements are required following internal audits, corrective action plans are developed, implemented, evaluated and closed out.</p> <p>Satisfaction surveys for residents and family are completed six-monthly as part of the internal audit programme. Surveys reviewed evidenced satisfaction with the services provided. This was confirmed by resident and family interviews.</p> <p>Monthly quality, health and safety and staff meetings evidenced quality improvement, risk management and clinical indicators are presented and discussed. Staff interviews reported that they are kept informed of quality improvements. Staff interviews, and meeting attendance records reviewed confirmed that attendance at staff meetings is facilitated.</p> <p>The facility utilises Oceania's documented quality and risk management framework that is available to staff to guide service delivery.</p> <p>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 their responsibilities to report hazards, accidents and</p> |

| | | |
|---|--------|--|
| | | incidents promptly. There was evidence of hazard identification forms completed when a hazard was identified and that hazards are addressed, and risks minimised. A current hazard register was available. |
| <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>The management team at the facility and the regional CQM are aware of situations which require the facility and the organisation 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 via Oceania support office staff. An unstageable pressure injury was reported to the Ministry of Health on the first day of the audit.</p> <p>A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the BCM. Staff interviews confirmed an understanding of the processes to follow when an adverse event or near miss occurs.</p> <p>Staff training records reviewed confirmed that staff receive education at orientation and as part of the ongoing training programme on incident and accident reporting processes.</p> <p>Accident/incident reports selected for review evidenced that where appropriate the resident's family had been notified, an assessment had been conducted and observations completed. Corrective actions arising from accidents/incidents were implemented. Family and resident interviews confirmed that family are notified where the resident has had an accident or a change in health status.</p> <p>Accident/incidents are graphed, trends analysed and benchmarking of data occurs with other Oceania facilities. Results from accidents/incidents inform quality improvement processes and are discussed at facility meetings.</p> |
| <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> | PA Low | <p>Human resource management policies and procedures align with the requirements of legislation.</p> <p>The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; identification verification; a position specific job description; and a signed employment agreement.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff and contractors that require them.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. Health care assistants (HCAs) are paired with a senior HCA until they demonstrate competency on specific tasks, for example: hand hygiene; medication, and moving and handling. Health care assistants</p> |

| | | |
|---|----|--|
| | | <p>confirmed their role in supporting and buddying new staff.</p> <p>The organisation has a documented role specific mandatory annual education and training module/schedule. The mandatory study days were provided in February and June 2019 and included but not limited to: infection control; restraint; fire safety; moving and handling; and wound management. There are systems and processes in place for staff to complete the required mandatory training modules and competencies, however not all HCAs directly involved in caring for residents in the dementia unit had completed the required unit standards relating to dementia care.</p> <p>The CM and nine other registered nurses (RN) have completed interRAI assessments training and competencies.</p> <p>Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of relevant education and training hours per annum. An annual appraisal schedule is in place. All staff files reviewed evidenced a current performance appraisal.</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> | FA | <p>The organisation's staffing and skill mix policy and formula provide guidance to ensure safe staffing levels within the facility meet the needs of residents' acuity and the minimum requirements of the DHB contract. 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 HCAs, available to safely maintain the rosters for the provision of care.</p> <p>Rosters sighted reflect adequate staffing levels to meet current resident acuity and bed occupancy. There is a RN on duty 24 hours a day 7 days a week. The BCM and CM work Monday to Friday and are on call after hours and weekends, seven days a week. There is the minimum contractual number of staff rostered on the night shift comprising of one RN and two HCAs.</p> <p>Observation of service delivery confirmed that resident needs were being met in a timely manner. Residents and family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed that whilst they are busy at times, they have enough time to complete their scheduled tasks and resident cares.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p> | FA | <p>The electronic medication management system, policies and procedures comply with medication legislation and guidelines. Medications are checked against the resident's medication profile on arrival from the pharmacy by a RN. Any errors by the pharmacy are regarded as an incident and referred to the pharmacy. 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 fridges where medications are kept, has a weekly temperature check within the recommended range. The drug register is maintained and evidenced weekly checks and six-monthly physical stocktakes. There is a process for checking and</p> |

| | | |
|---|----|--|
| requirements and safe practice guidelines. | | <p>managing expired medicines.</p> <p>Three-monthly medication reviews are conducted by the GP/NP and any discontinued medicines dated and signed. Medication administration observed met legislative requirements. Administration records are maintained. There is evidence outcomes are recorded for as required pain medication administered. Oxygen was charted as required.</p> <p>Staff attend annual medication education. Staff administering medicines, including RNs and senior HCAs, have completed medication competencies.</p> <p>There were no standing orders in use at the time of audit. There were no residents who were self-administering their medication at the time 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>The kitchen manager oversees food provision at Wharerangi. They are supported by two cooks and two kitchen assistants. All kitchen staff have safe food handling qualification and had completed relevant food handling training. The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people. The menu has been reviewed by a dietitian. A current food control plan, last verified in June 2019, has been implemented. Food procurement; production; preparation; storage; transportation; delivery and disposal comply with current legislation and guidelines.</p> <p>Residents' dietary profiles are completed by the RN on admission, identifying the residents' dietary requirements and preferences. There were current copies of the residents' dietary profiles located in the kitchen. Special equipment to meet residents' nutritional needs and disabilities, was sighted. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> <p>Residents and families interviewed confirmed satisfaction with the food service.</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>The care provided is consistent with the needs of the residents. In files sampled the PCCPs evidenced detailed interventions based on resident's current needs, goals and desired outcome. There is evidence of referrals to specialist services such as: podiatry; physiotherapy; dietitian and wound specialist nurses. The GP/NP records reviewed are current. Nursing progress notes and observation charts are maintained. Family communication is recorded in the residents' files.</p> <p>There were adequate supplies of products and equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p> <p>Staff interviews confirmed they are familiar with the needs of the residents they are allocated to. This was</p> |

| | | |
|---|----|---|
| | | also evidenced by discussions with residents and families. |
| <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>A social assessment and history is undertaken on admission to ascertain: residents' needs; interests; abilities; and social requirements. A memory lane booklet provides a profile and life journey for each resident. Review of files evidenced assessments and reviews were up to date. Attendance and participation in activities is documented. Activities monthly progress reports entered in the residents' clinical files evidenced outcomes against resident goals. The activities coordinator interviewed stated that they participate in six monthly multidisciplinary meetings as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted is developed and implemented by the activity's coordinator, with involvement of a diversional therapist. The activities programme provides a range of activities that match residents' strengths and interests which include the involvement of the community. On the day of audit, residents including dementia care persons, were observed being actively involved with a variety of activities within the main lounge. Some residents attend activities of interest in the community. All residents have access to the three times weekly van outings. Residents who prefer to stay in their room have one-on-one visits including, for example, pamper sessions and outings in the wheelchair.</p> <p>Interview with the activity's coordinator confirmed they conduct two monthly residents' meetings and that residents provide feedback on activities of their choice. Review of meeting minutes indicated residents' input is sought and responded to.</p> <p>The residents and their families interviewed reported satisfaction with the activities provided and that activities provided are meaningful to them.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>There was documented evidence that RN evaluations were current and completed for all care plans sampled. Care plan evaluations are conducted by a RN, with input from residents, family, HCAs, activities staff and GP/NP. There was evidence of allied health care staff input when this was required. Reviews include the degree of achievement towards meeting desired goals and outcomes.</p> <p>Resident care is evaluated on each shift and reported in the residents' progress notes. If any change is noted, it is reported to the RN or the CM. A short-term care plan is initiated for short-term concerns, such as infections and wound care.</p> <p>Interviews verified residents and family/whānau are included and informed of all changes.</p> |
| Standard 1.4.2: Facility | FA | There is a current building warrant of fitness that expires on 31 May 2020. There have not been any |

| | | |
|--|----|---|
| Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | | structural alterations to the building since the last audit. |
| 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 | <p>The infection prevention and control surveillance policy identify the requirements around the surveillance of infections. The type of surveillance undertaken is appropriate to the size and complexity of this service. Infection logs are maintained for infection events. Internal audits are completed. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the CM, 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.</p> <p>One of the RNs is the infection control nurse. Infection data is collated monthly by the infection control nurse and CM. This data is submitted to Oceania national support office where benchmarking is completed. The data is analysed for trends and reported at the monthly infection control meeting and at the monthly staff and quality meeting for all staff.</p> <p>Interview with the infection control nurse confirmed there had been no outbreaks since the previous audit.</p> |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | <p>The Oceania Healthcare Limited restraint minimisation and safe practice handbook and policies guide safe practice at Wharerangi. The CM and RN interviews confirmed there is a restraint free philosophy at the facility. The restraint coordinator (RC) is a RN. A signed position description was sighted. Interview with the RNs and HCAs confirmed their understanding that enablers are voluntary, and the least restrictive option to maintain resident independence and safety.</p> <p>There were no residents using restraint or enablers during the on-site audit days.</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) |
|--|-------------------|--|---|--|
| Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is an annual training plan for the facility. Staff attend mandatory training and education days and additional training and education is provided. Review of education logs for HCAs who work in the dementia unit evidenced not all HCAs have completed the required unit standards relating to dementia care within the 12 months of their appointment. | Not all health care assistants who work in the dementia unit have completed the required dementia training within the 12 months of their appointments | Provide evidence all health care assistants who work in the dementia unit have completed the required dementia training within the 12 months of their appointments 180 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, there 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.