Oceania Care Company Limited - The Oaks Rest Home and Village

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:	The Oaks 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: 10 March 2020 End date: 11 March 2020

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: 95

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

The Oaks Rest home and Village provides rest home and hospital level care for up to 105 residents. There were 95 residents at the facility on the first day of the audit.

This unannounced surveillance audit was conducted against the relevant Health and Disability Services Standards and the service's 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 residents, family members, management, staff and general practitioners.

There were eight areas requiring improvement from the previous audit. Seven previous requirements for improvement have been closed out relating to complaints management; collection of quality improvement data; staff orientation; ongoing staff education and performance reviews; emergency management; timeframes of service delivery and restraint minimisation. There previous requirement for improvement relating to corrective action plans remains open.

A new area identified as requiring improvement at this surveillance audit relates to medication management.

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 accessible to residents and families. This information is brought to the attention of residents and their families on admission to the facility. Residents and family members confirmed their rights are being met, staff are respectful of their needs and communication is appropriate.

Open communication between staff, residents and families is promoted and documented. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

There is a documented and implemented complaints management system. The business and care manager is responsible for managing complaints.

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 medium or high risk and/or unattained and of low risk.

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 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 and facility's quality management programme. The facility management team is supported by the regional clinical quality manager and the regional operations manager.

The facility implements the Oceania Healthcare Limited quality and risk management system that includes collection and analysis of quality improvement data to identify trends and lead to improvements. Quality and risk performance is monitored through the organisation's reporting systems. An internal audit programme is implemented.

Policies and procedures that support service delivery are current and align with good practice, legislation and guidelines. Monthly reports to the national support office allow for the monitoring of service delivery. Oceania Healthcare Limited human resource policies and procedures are documented and implements by The Oaks. 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 residents' acuity needs.

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.

Residents receive services which are timely, coordinated and customised to their assessed needs.

Care is provided to residents using a team approach that includes but is not limited to: registered nurses; general practitioners; health care assistants; a diversional therapist; and a physiotherapist. Residents' clinical records are held and updated within electronic software. Assessments including interRAI inform care plans. Interventions were documented in the care plans to assist residents to meet their goals. Care plan evaluations and interRAI reassessments were completed within the requirement timeframes.

There is a varied activities programme designed to meet residents' interests.

Medication management is guided by a policy that reflects legislation and best practice guidelines. Staff administering medication have current competencies.

Meals are prepared on site in a kitchen with a current food control plan. The menu is planned by a registered dietitian and individual residents' needs and likes and dislikes are catered for.

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.

Essential emergency systems are in place and ready to be activated when required. Staff complete emergency training.

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.

There is an restraint and enabler policy which meets the restraint minimisation and safe practice standards and includes monitoring through an enabler register. There were three enablers in use during the audit and no restraints were being used. Staff receive education relating to the use of and management of restraints and enablers.

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.

There is an infection prevention and control policy in place to guide practice. The policy includes strategies to minimise the outbreak of an infection. Results of surveillance are acted upon, evaluated and reported to the organisation's governing body.

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	16	0	0	2	0	0
Criteria	0	40	0	0	2	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	The business and care manager (BCM) is responsible for complaints management. The complaints policy and associated forms comply with Right 10 of the Code. Residents and families receive information on the complaint process on admission. The complaints forms are displayed at reception and accessible within the facility. Staff explained the right for residents to make a complaint and the complaint process. The complaints register reviewed showed written and verbal complaints recorded over the past year, including dates and responses. Documentation of actions taken included agreed resolutions, required follow up and corrective actions (refer to 1.2.3.8). Family and residents interviewed were aware of the complaints process and how to make a complaint. The previous requirement for improvement for the complaints processes to adhere to the Right 10 of the Code is closed. There was one anonymous complaint that had been investigated by the DHB and review of the records evidenced the facility provided information and the complaint is now closed. There were no other complaints with external agencies.
Standard 1.1.9:	FA	Residents and family members stated they were kept informed about any changes to their relative's status; were advised in a timely manner about any accidents/incidents, and about the outcomes of regular or urgent medical

Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		reviews. Communication to families was documented in the residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements the Health and Disability Commissioner's Code of Health and Disability Services Consumers Rights (The Code). Resident and family members reported that they are informed of residents' meetings which are held monthly and that they attend as able. Review of meeting minutes evidenced information is shared such as survey results and that there is an opportunity to provide feedback on services. Family and staff interviews identified there is a family newsletter emailed to all family members to keep them informed. Staff demonstrated they know the process to access interpreter services when required. Interpreter services can be accessed via the district health board (DHB) or Interpreting New Zealand. There was one resident who do not speak English at the time of audit. Staff interviewed identified they utilise communication cards and are able to identify the resident's needs.
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 Oaks Rest Home and Village (The Oaks) is part of the Oceania Healthcare Limited (Oceania). The Oceania executive team provides support to the facility with the regional clinical and quality manager providing the support during this on-site audit. The BCM provides the executive management team with monthly progress against identified indicators. Oceania has an overarching business plan and The Oaks has a business plan specific to the facility. Posters observed at the entrance of the facility and information booklets available for residents, staff and family include the organisation's mission statement, values and goals. The service is managed by a BCM who has been in this role for two years. The BCM is a registered nurse (RN) and has had previous management experience of residential care facilities. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The BCM is supported by a clinical nurse manager (CNM) who has been in the role since February 2019. The CNM is a RN with experience in aged residential care. Both the BCM and the CNM have undertaken Oceania training and education relevant to their positions. The facility can provide care for up to 105 residents, with 95 beds occupied at the audit. This included 58 residents requiring rest home level care, 37 requiring hospital level care. Included in the occupancy numbers were: two residents under 65 years of age were receiving hospital care under a long-term chronic condition contract, one resident was under a palliative contract in rest home care, and one resident under accident corporation contract (ACC) for extended respite care at rest home level. Not included in total occupancy numbers were two self-funding residents. The facility includes hospital and rest home service with occupational rights agreements (ORA). Included in total occupancy numbers were 27 ORAs at rest home level care. The services for residents with ORA are the same as

		services for rest home and hospital services for residents under the age-related residential care contract and other contracts at the facility.
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.	PA Moderate	The Oaks uses the Oceania quality and risk management system that reflects the principles of continuous quality improvement. The Oceania management group reviews all policies with input from internal experts. Policies reviewed cover the necessary aspects of the service and contractual requirements, including reference to the InterRAI long-term care facility (LTCF) assessment tool and process. Policies include references to current best practice and legislated requirements. New and revised policies are introduced to staff at staff meetings and policy updates are also presented as part of relevant in-service education. Staff interviewed confirmed that they are alerted of new and revised policies and receive opportunities to read and understand these policies. The document control system ensures a systematic and regular review process, including the approval, distribution and removal of documents. Service delivery is monitored through complaints, review of incidents and accidents, key performance indicators, and implementation of an internal audit programme. The internal audit programme is documented and implemented as scheduled. Internal audits cover all aspects of the service and are completed by the BCM or CNM. Audit data is collected, collated and analysed at the facility. Results are reported on electronic system which can be viewed by Oceania national support office. Interviewed staff reported that they are kept informed of audit activities and results at staff meetings. Satisfaction surveys for residents and families are completed as part of the internal audit programme on a six-monthly basis. Interviews with staff, residents and family confirmed a satisfaction survey was taking place at the time of audit. Survey forms were observed to be available within the facility. The September 2019 survey had been collated and analysed and communicated to staff, family and residents as evidenced in meeting minutes and interviews. The previous requirement for improvement relating to internal audits being completed according to the schedule by an appropriate staff member and collation and communication of survey data has been closed out. Facility meetings are conducted, including for example, general staff and quality initiative meetings, RN meetings, household staff meetings and kitchen staff meetings. Minutes of meetings evidenced communication with staff around aspects of quality improvement and risk management. Clinical indicators are collated monthly and benchmarked against other Oceania facilities. Corrective action plans reviewed during on-site audit evidenced timeframes were not consistently adhered to or the effectiveness of the plan evaluated. The previous requirement for improvement from previous audit relating to corrective action planning remains open. The Oaks has a risk management programme in place. Health and safety policies and procedures are documented

		along with a hazard management programme. There was evidence of hazard identification forms completed when a hazard was identified. The BCM is responsible for maintaining the hazard register and is the health and safety officer. A hazard register is available which details how the hazards are addressed and the risks minimised. The hazard register is current as sighted during on-site audit. Staff interviewed confirmed awareness of the process to report hazards.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff interviewed understood the adverse event reporting process in relation to their professional practice and regulatory requirements. They were also able to describe the importance of reporting near misses. The BCM demonstrated in interviews they were aware of situations in which the service would need to report and notify statutory authorities including police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks; and changes in key managers. Authorities have been notified of the new CNM appointment. Staff who witness an event or are first to respond to an event document adverse, unplanned or untoward incidents in the reviewed accident/incident forms. Accident/incident forms evidenced family were contacted following any adverse event. The RN documents assessments of residents following an accident/incident. This includes neurological observations and falls risk assessments as appropriate. Managers sign off the accident/incident forms (refer to 1.2.3.8). Policy and procedures comply with essential notification reporting, for example health and safety, human resources and infection control.
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 resources management policies and processes are based on good employment practice and relevant legislation. A sample of staff records reviewed confirmed the organisation's policies are consistently implemented and records are maintained. Professional qualifications are validated. There are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced in reviewed records for all staff and contractors that require them. Staff orientation documentation sighted include necessary components to the role. Health care assistants (HCA) interviewed identified they are paired with a senior HCA until they demonstrate competency on specific tasks such as hand hygiene or moving and handling. Staff interviewed reported that the orientation process prepared them well for their role. Staff records reviewed show consistent documentation of completed staff orientation. The previous area requiring improvement related to documented evidence that staff complete orientation is now closed. The organisation has a documented mandatory annual education and training module/schedule. The mandatory

		study days of continuing education include infection control, restraint/enabler use, moving and handling. There are systems and processes in place, including texting staff to remind them of the required mandatory modules and competencies training dates. Interviews confirmed that all staff, including RNs, undertake at least eight hours of relevant education per year and that an appraisal schedule is in place. Staff education records evidenced the ongoing training and education completed. Fifteen RNs including the CNM were identified as interRAI competent. Staff files reviewed also show consistent documentation of annual performance reviews. The previous requirement for improvement to ensure all staff complete annual education and performance reviews is now closed.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The organisation has a documented and implemented process for determining staffing levels and skill mixes which support safe service delivery, 24 hours a day, 7 days a week. The facility adjusts staffing levels to meet the changing needs of residents by using the flexible roster. Rosters include a flexi-shift which is an HCA or RN who can work in any service area as dictated by service requirements. Health care assistants interviewed reported there were adequate staff available to complete the workload and specific tasks allocated to them. Residents and families interviewed supported this. Review of a four-week roster cycle confirmed staff cover is provided in line with the DHB contract, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. There is RN coverage 24 hours, 7 days a week. The BCM and CNM work Monday to Friday and are on call after hours and weekends, seven days a week. The ORA units are located within the facility in close proximity to the RN office. The residents who receive rest home care and hospital level care in ORA units were observed to have their needs met within the environment in which they live with: 24 hour care, adequate HCA and RN cover, and provision of services in accordance with the agreed related residential care agreement.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	PA Moderate	There is a current medication policy which reflects best practice guidelines. Medication is provided by a local pharmacy in response to the receipt of a prescription. A RN checks all medication on arrival against the prescription. Residents' regular medication is received in pre-packaged sachets. An electronic medication management system was observed to be in use, with prescribing, administration and review occurring within appropriate timeframes, including as required medications. Medication charts sighted had a photograph that was a true representation of the resident. Medication fridges were sighted and temperature recordings were documented as per policy. Oral, intramuscular and intravenous medication is stored in compliance with policy and legislation. The drug register evidenced weekly and six monthly checks as well as pharmacy involvement. However, it was observed that not all eye drops and/or ointments stored in the ward medication trolley had opening dates documented, and not all dressing solutions and

guidelines.		lotions stored on the dressing trolley had opening dates documented. Registered nurses attend annual medication training updates and are competent to administer medication. Health care assistants administer medication when competent to do so, as confirmed by staff interviewed. No residents were self-administering medication during the audit, however; the policy provides direction to facilitate this as per request. A medication round was witnessed and demonstrated practice that reflected policy and best practice guidelines, including medicine management detailed recording and communication to residents.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The seasonal menu proposed to residents was sighted, along with evidence that it was developed by a registered. Satisfaction surveys relating to food services are undertaken, the BCM collates the results which are incorporated into the meal service plan. plans. Residents interviewed expressed satisfaction with the meal quality and delivery. Residents' special dietary requirements and preferences are assessed by RNs, who notifies the kitchen where it is displayed as a guideline for staff. Specialised crockery and cutlery are observed to be available to residents as required. All food is prepared an on-site. There was a current food control plan at the time of the on-site audit. The kitchen was observed to have food preparation, serving and cleaning areas, all of which were clean and tidy. Kitchen, refrigerator and freezer cleaning records were sighted, as were maintenance records. Refrigerator and freezer temperature monitoring charts are kept as per cold chain management procedures as sighted during on-site audit. All prepared food was seen to be covered, dated and stored in the refrigerator. Food ingredients were stored in sealed containers in a pantry, with visible opening dates. All crockery and cutlery are stored in a clean covered storage area. Pest control is managed by a contracted service provider. Meals and snacks are prepared, cooked and served in the kitchen; with some of the food being placed in bain-maries to be transported to two serving stations in other parts of the facility. Food serving temperature records were sighted at each serving station. The chef and two kitchen assistants were interviewed, were able to discuss food preparation, serving policy and process, and details of food safety standards. All staff interviewed held recognised qualifications for the position. Food procurement, production, preparation, transportation, storage, delivery and disposal comply with current

		legislation and guidelines.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Clinical files reviewed contained a current PCCP with records of interventions to meet the residents' needs and desired outcomes. There was documented evidence of multidisciplinary team collaboration and allied health ongoing involvement in services such as podiatry, hearing services and ophthalmology. Documentation of GP reviews within timeframes required by the aged residential care contract or more often if required was sighted. Residents and families spoken to confirmed they had regular access to general medical practice. Families stated they were notified and updated of resident medical progress following GP consultations. Wound care plans sighted reported interventions performed to promote healing and their rationale. Registered nurses interviewed explained they access and seek advice from a wound clinical nurse specialist when required. All staff interviewed confirmed access to adequate supplies of clinical resources and consumables, including dressing and incontinence products. This was confirmed by observation during the audit.
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' activities programme is planned and run by a registered diversional therapist (DT), with the help and support of an assistant. A monthly plan is displayed in prominent positions throughout the facility including in the resident's bedroom as sighted during the on-site audit. The programme contains a variety of activities to meet the needs of residents, and includes an exercise programme, outdoor activities, outings, and cognitive games. Consideration is given to residents' cultural needs. Residents are provided opportunities to share and learn about multiple cultures. The DT was interviewed and stated that the required support and resources to deliver a meaningful programme to all residents were available. During the audit, residents were seen partaking in a wide range of activities. Residents and family members interviewed confirmed they were satisfied with the range of activities offered. Formal feedback is sought from residents and families on the programme and collated by the BCM. The BCM and the DT meet monthly to review the programme feedback and activities attendance records. When a resident systematic absence is noted, a one to one debriefing session is arranged with their agreement, in order to comprehend and facilitate personal engagement. Individual participation and interest in activities was documented through the clinical files sampled as an inclusion in the goals, evaluation, and review of the PCCP.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Evaluation of the residents' care is continual and undertaken using a team approach that includes HCAs; the DT; GP; and RNs. Each shift a RN makes an entry in the clinical record as evidenced in records reviewed. The entry summarises the resident's overall health status, any variance in health status and the resident's response to the care provided during the shift. Person centred care plans are re-evaluated six-monthly or more frequently if required. Evidence of timely evaluation was sighted in the clinical records. The process is led by a RN in collaboration with the multidisciplinary team. It includes consideration of the interRAI assessment, which is also updated six-monthly or more often if required. Short-term care plans are evaluated in a timely manner and signed off when the desired outcome is met. When the care progress differs from the expected outcome, the plan and/or the goal are re-assessed and modified as required. Evidence of re-assessment and modification of care plans and goals was sighted in clinical records sampled and confirmed by interviews with RNs. Residents and family interviewed confirmed their involvement in comprehensive care plan review and their awareness of care plans revisions, both short-term and long-term.
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 publicly displayed. There have not been any structural alterations to the building since the last audit.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security	FA	Policies and guidelines for emergency planning, preparation and response, are observed on display and known to staff interviewed. Disaster and civil defence planning guides direct the facility in their preparation for disasters, by describing the procedures to follow in the event of a fire or other emergency. Staff interviewed confirmed their knowledge of emergency procedures. Staff file reviews evidenced that all RNs had current first aid certificates. Rosters confirmed that there is a staff member on each shift with a current first aid certificate. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas barbeques were sighted and meet the requirements for the size and complexity of the facility. Residents' registers in the emergency cupboards are current. The previous corrective action regarding emergency staff training and emergency preparedness is now closed.

situations.		
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 Oaks has an established infection control plan and programme that includes surveillance in regard to the size and complexity of the organisation. The CNM leads the infection control programme, inclusive of surveillance in collaboration with external consultants and the Oceania support office. Surveillance information is collected by RNs who document diagnosed infections within the service. Information is collated monthly by the CNM and subjected to internal Oceania benchmarking. Information related to trends and/or actions for infection management are reviewed at monthly quality meetings. Meeting minutes reviewed reflect a proactive response to preventable infections. Infection control actions are evaluated. A quality meeting was observed where information about infection control programme and surveillance was discussed. The Oaks records' evidenced one outbreak of infection in June/July 2019. Outbreak management documentation confirmed the required notifications to the DHB infection control nurse, GP, Public Health and Section 31 reporting. Outbreak closure documentation reported: outbreak management that followed infection control policy requirements and sufficient resources to manage the outbreak.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraints and enablers are defined within the documented restraint minimisation policy and in line with relevant standards. The document provides guidelines and strategies to minimise the use of restraint. During the on-site audit, no restraints were in use and three enablers were in use. An enabler register is maintained and was sighted. There was documentation showing that residents and their families had voluntarily requested and consented to the use of an enabler as a means to increase safety or comfort. There was additional evidence that monitoring and evaluation of enablers usage occurs. Staff interviewed were familiar with the policy and able to discuss strategies to avoid restraint use. There was evidence to confirm that all staff receive annual training related to the use of restraints and enablers.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The need for restraint is assessed by the CNM, a restraint assessment authorisation and plan tool is utilised to facilitate an assessment of the resident prior to implementing restraint. The tool meets the requirements of the standard. There were no restraints in use at the time of the audit. General practitioners interviewed confirmed that restraints were rarely used in the service, and that if restraint was used, they were involved in any decision making with regard to the use of restraint. Staff interviewed stated that restraints were rarely used and that the CNM assesses residents prior to using restraint. Documentation was sighted which confirmed residents who had used a restraint in the past had a completed assessment as per the standard and there was evidence alternative strategies were considered. There were three residents using an enabler during the audit (bedrails). Two of the three enablers were sighted and

		observed to have protective covers in place. Changes have been implemented to address the previous finding relating to documentation of alternative strategies and bedrail covers.

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 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	Managers interviewed demonstrated an understanding of the requirements for corrective action plans and their implementation. Where issues were identified in internal audits, complaints and accidents/incidents reports, corrective action plans were in place. Timeframes for implementation were specified in corrective action plans, however, there was inconsistent evidence that actions were implemented within the timeframe specified. The actions for implementation identified in correction action plans did not consistently evidenced documented evaluation of actions undertaken.	Corrective actions plans following internal audits, complaints and accident/incidents reports, do not consistently evidence adherence to timeframes or documentation of evaluation.	Provide documented evidence that corrective actions are implemented within specified timeframes and actions are evaluated. 90 days

Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	Medications sighted were stored in a temperature-monitored environment that was unable to be accessed by unauthorised persons. The Oceania medication management policy details that the dates medicines are opened should be recorded. However, observation identified that not all eye drops and nasal sprays had the date of opening documented on the bottle. The wound care trolley was stocked with products and solutions to meet the needs of the residents, however, not all wound care solution bottles, wound care lotions and/or ointments had an opening date documented on the container.	Not all medications and wound care solutions were stored in compliance with policy, guidelines, protocols and legislation.	All medications and wound care solutions are to be stored in compliance with policy, guidelines, protocols and legislation. 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.