Capital Residential Care Limited - Ocean View Residential Care

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:	Capital Residential Care Limited
Premises audited:	Ocean View Residential Care
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 April 2021 End date: 16 April 2021

Proposed changes to current services (if any): The service has converted two large bedrooms, currently certified as single to two double bedrooms. They have converted the bedroom of a previous apartment as a single bedroom.

The service has converted two large bedrooms, currently certified as single to two double bedrooms. They have converted a spare storage room as a single bedroom. The addition of the two beds (two rooms becoming double rooms for couples) and the addition of one new single bed room, taking the total number of beds to 24. A request for reconfiguration of bed numbers has been made to

the district health board and the Ministry of Health for the addition of three additional beds. These rooms were verified as part of this audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 18

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

Oceanview Residential Care is privately owned and operated. The service is currently certified to provide rest home care for up to 21 residents with 18 residents on the days of audit. As part of this audit, three extra beds were verified as suitable for rest home level care taking the total number of beds to 24.

This certification audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

One of the owners is the manager. An administrator, second owner, and clinical nurse manager support the manager. Residents and relatives interviewed were complimentary of the care and support provided. The service has made a number of environmental improvements since the previous audit. A quality and risk management system continues to be implemented.

An improvement is required in relation to maintenance.

The service has been awarded a continued improvement rating around good practice related to clinical documentation.

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.		All standards applicable to this service fully attained with some standards exceeded.

Staff at Oceanview strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Staff interviewed were familiar with processes to ensure informed consent. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns policies are documented, and the complaints process is known by residents and relatives.

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.

Oceanview is certified to provide rest home level of care. The manager (owner) has the responsibility of running the facility with support by a clinical nurse manager. The quality and risk management programme includes service philosophy, goals and a quality planner. Residents' meetings have been held and residents have been surveyed. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and managed. Staff files are maintained, and annual appraisals have been conducted. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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.

The facility works with the Needs Assessment Coordination Service to ensure access to the service is effective with all relevant information available, when a resident seeks to access the facility. There is an admission package available prior to or on entry to the service.

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.

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 service has implemented an electronic medication system. The general practitioner reviews the medication charts three monthly.

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.

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 provide the food service. The residents verified satisfaction with meals.

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

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.		Some standards applicable to this service partially attained and of low risk.

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.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility.

Resident bedrooms are personalised. There are adequate numbers of communal toilet/shower facilities. Cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services.

The facility has a monitored call bell system for residents to summon help, when needed, in a timely manner.

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

Restraint minimisation and safe practice

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

The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints or enablers at the time of the audit.

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.

A registered nurse is the designated infection control coordinator and oversees the infection prevention and control programme. The infection control coordinator can contact the DHB infection control nurse specialist or GP at any time for advice and information. The infection prevention and control policies are comprehensive. Infections are collated monthly, and trends are identified and used to identify education needs or generate improvement in practice. Staff have annual infection control training and there are implemented internal audits around the environment and cleanliness that ensures that infection control is monitored.

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	1	43	0	1	0	0	0
Criteria	1	91	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (three caregivers, one activities coordinator, one RN who is the clinical nurse manager, the administrator, cook and the manager/owner) confirmed their familiarity with the Code. Interviews with four residents and four relatives confirmed the services being provided are in line with the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in five resident files reviewed Resuscitation plans were sighted in the five long-term resident files reviewed. Copies of EPOA were on files as required. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Four family members and four residents interviewed, confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been

		provided. All resident's files reviewed had signed admission agreements.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	An advocacy policy and procedure include how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are available in advocacy pamphlets that are available at reception.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interviews with residents and relatives, confirmed that visiting can occur at any time. Family members were seen visiting on the day of audit. Key people involved in the resident's life are documented in the care plans. Discussions with residents and relatives, verified that they are supported and encouraged to remain involved in the community. Oceanview's staff support ongoing access to the community. Entertainers are invited to perform at the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained using a complaints' register. There have been three complaints made in the 2019/2020 period and no complaints year-to-date for 2021. Three complaints reviewed included one in 2020 made by a relative to the DHB. The DHB investigated and deemed the complaint unsubstantiated. The other two complaints had been followed up and responded to appropriately. Residents and relatives interviewed advised that they are aware of the complaints' procedure. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that includes the Code, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents and relatives identified they have been provided with information about the code. Resident meetings have been held providing the opportunity to raise concerns in a group setting. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy

		services, objectives and process/procedure/guidelines.
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 service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff could describe the procedures for maintaining confidentiality of resident records and personal privacy for residents. Residents and relatives interviewed confirmed the service is respectful and that they are given the right to make choices. Care plans reviewed identified specific individual likes and dislikes. Staff education and training on abuse and neglect and informed consent has been undertaken in the 2020/2021 year.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There is a Māori heath plan and an individual's values and beliefs policy, which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the diverse cultural needs of residents and their whānau. One resident identifies as Māori, and caregivers interviewed were able to discuss cultural needs for this resident. Policies include guidelines about the importance of whānau. The service has links to a Māori cultural advisor and has a number of staff who identify as Māori.
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	Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. All relatives interviewed reported that they feel they are consulted and kept informed. Family involvement is encouraged. Care plans reviewed included detailed information relating to the residents' social, spiritual, cultural and recreational needs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes dignity and privacy and boundaries. Interviews with staff confirmed their understanding of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	The service has a documented quality programme designed to monitor compliance and care. Staffing policies include pre-employment, and the requirement to attend orientation and undertake ongoing in-service training. Policies and procedures are in place and document an annual review. Staff meetings and residents' meetings have been conducted.

		Residents and relatives interviewed, spoke very positively about the care and support provided. There are clear ethical and professional standards and boundaries within job descriptions. The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. A programme of staff education and development regarding progress note reporting has been carried out over the last year.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. The facility manager and clinical manager confirmed family are kept informed. The relatives interviewed, stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Oceanview is privately owned and operated. One of the owners is the manager and there is an experienced Clinical Nurse Manager who is responsible for all clinical care and involved in the overall management. The service is certified to provide rest home care for up to 21 residents, with 18 residents on the day of audit. One resident was an ACC long-term resident, one a respite resident and all other residents were under the age-related residential care services agreement. As part of this audit, three extra beds were verified as suitable for rest home level care. The service has converted two large bedrooms, currently certified as single to two double bedrooms. They have converted the bedroom of a previous apartment as a single bedroom. The addition of the two beds (two rooms becoming double rooms for couples) and the addition of one new single bed room, taking the total number of beds to 24. A request for reconfiguration of bed numbers has been made to the district health board and the Ministry of Health for the addition of three additional beds. Oceanview has documented goals and objectives for business management, quality and risk

		management, the service environment and resident service delivery. The mission statement includes providing quality care and independence within a happy, safe, friendly environment. An annual review of the quality and risk management programme has been completed. The owner/manager has been in the role for six years and is supported by a co-owner and an experienced clinical nurse manager. The manager has undertaken education relevant to his role. An administrator, a registered nurse and care staff also support the managers.
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	There is a registered nurse (a senior registered nurse who undertakes on call and works at the home part time) who relieves for the clinical nurse manager as required and the administrator and clinical nurse manager relieve for the manager/owners.
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	Oceanview has a documented quality and risk programme. There are annual reviews documented for activities, health and safety, risk management, complaints, infection control and medications. This information has been used to formulate ongoing business and quality plans. There are policies and procedures documented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies. The Oceanview owners are at the site Monday to Friday with the manager/owner often at the site on weekends also. Monthly quality meetings (sometimes fortnightly) are held and for the owner(s) and senior staff to discuss and monitor the progress of processes and plans for the service. Minutes of these minutes evidenced discussion on health & safety, infection control along with other issues (e.g., corrective actions resulting from audits). There are two monthly staff meetings. Minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. The staff interviewed were aware of quality data results, trends and corrective actions. There is an internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Internal audits have been completed as per schedule, reported to the quality meeting and staff meeting and corrective

		actions undertaken and re-audited as appropriate. There is an implemented health and safety and risk management system in place including policies to guide practice. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings. A resident survey for 2020 notes overall satisfaction. In total three persons expressed dissatisfaction with an aspect of the service (different aspects). These have been followed through with documented corrective actions which have been undertaken. Falls management strategies include assessments after falls and individualised strategies. The service has emergency plans covering all types of emergency situations and staff receive ongoing training around this.
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	The service collects incident and accident data and enters them into a register. There are monthly reports which are discussed at the quality and health and safety meetings. Seven incident forms were reviewed, one fall (witnessed), four behaviours that challenge and one needlestick injury. All incident forms identified a timely RN assessment of the resident/staff and corrective actions to minimise risk. The next of kin had been notified for all required incidents/accidents. The caregivers interviewed could discuss the incident reporting process. The clinical manager collects incident forms, investigates and reviews and implements corrective actions as required. The clinical nurse manager interviewed could describe situations that would require reporting to relevant authorities. There has had one DHB investigation into a complaint – found to be unsubstantiated.
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	There are human resources policies to support recruitment practices. Five staff files were reviewed (one RN/CNM, two caregivers, one recreation officer and one cook). All files contained relevant employment documentation including current performance appraisals (except for two who were new employees) and completed orientations. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of care. Staff interviewed believed new staff are adequately orientated to the service on employment. There is an annual education planner in place, the service provides both online training and in-service training. The planner and individual attendance records are updated after each session.

		Additional subjects relating to infection control had been added. The clinical nurse manager has completed interRAI training.
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 policy to determine staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager/owner (non-clinical) and the clinical nurse manager/RN are on duty during the day Monday to Friday. A casual RN is also available when needed. An administrator is on duty Monday to Friday. The AM staffing includes two caregivers, one 7 am to 2 pm and 7 am to 10.30 am (till 1 pm on weekends). The Recreation Officer is on 9 am to 12.30 pm weekdays. The PM staffing includes two caregivers, one 4 pm to 11 pm and one 2 pm to 8 pm. There is one caregiver on night shift. There is a cook and a kitchenhand, seven days a week and a laundry/housekeeper, seven days a week. Residents and relatives interviewed stated there were adequate staff on duty at all times. Staff stated they feel supported by the RN, and clinical nurse manager who respond quickly to after-hour calls.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Other residents or members of the public are unable to view sensitive resident information.
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	Prior to residents entering to the facility, Needs Assessment Service Coordination (NASC) assesses potential residents as requiring rest home level care. The service communicates with the NASC and other appropriate agencies to ensure efficient, appropriate and timely admission. The facility provides residents and families with an information pack containing all pertinent information. Resident's admission agreements evidenced resident and/or family and facility representative sign off. Exclusions from the service are included in the admission agreement.

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 achieved in a strategic and coordinated manner. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident, this was witnessed on site in review of resident's files. Families interviewed reported timely communication from the facility.
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 an electronic medication system in place with appropriate processes that comply with current legislation requirements and safe practice guidelines. The medication areas evidence an appropriate and secure medicine dispensing system. Medications are stored free from heat, moisture and light, in original dispensed packs and in a secure trolley. The controlled drug register is maintained and evidenced weekly checks and six monthly physical and pharmacy stocktakes. There were no controlled drugs on site on the day of audit. Records of temperature checks for the medicine fridge and medication cupboard are maintained and demonstrated evidence of temperatures being within the recommended range. All staff authorised to administer medicines have current competencies. A medication round was observed and evidenced the staff member was familiar about the medicine administered. Medications were signed off, after the dose was administered, protocols and procedures were followed. Administration records and specimen signatures are maintained. There is a policy for residents who self-administer medications; currently there was one resident partially self-administering medicines at the facility (allowing autonomy for the resident at their request but fully supervised by the staff with drugs stored in the medication trolley). Ten medication charts and signing sheets were reviewed on the electronic medication system. All charts had photo identification and allergy status identified. Prescribing for 'as required' medications had indications for use prescribed. The regular and 'as required' medications are delivered in blister packs and there is evidence of medication reconciliation carried out by the clinical nurse manager. All medications are stored safely.
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	FA	All meals and baking at Ocean View are prepared and cooked on site by cooks. The cooks are supported by a breakfast caregiver, and one afternoon caregiver heats and serves the pre-prepared evening meal. The menu reviewed is in line with recognised nutritional guidelines for older people, as verified by a dietitian's assessment this month. In the past year there has been an upgrade of the kitchen inclusive of a new oven and extractor

delivery.		fan. There was documented evidence of residents and families being satisfied with the meals provided, and this was confirmed on interview with residents and families. Residents continue to give feedback about the food at the residents' meeting. The residents' files demonstrated monthly monitoring of individual resident's weight. Special equipment, to meet residents' nutritional needs, was sighted, and there was evidence of adequate crockery. A dietary assessment is completed for each resident on admission and a dietary profile developed. The dietary assessments, including allergies, likes and dislikes, are located in the residents' files and the kitchen. The individual resident food plan is reviewed by the cook to reflect and confirm the residents' dietary requirements. When interviewed the cook confirmed all residents' dietary needs were reviewed as needed and/or if there was a change in a resident's need or health status. Dietary requirements, cultural and religious food preferences are met. Gluten-free, high protein diets and diabetic desserts are accommodated. The service operates an approved food control plan which is due for renewal on 4 September 2021. Food temperatures are monitored and recorded as part of the food control plan. The two cooks have undertaken safe food handling qualification (NZQA 167) and completed relevant food handling training. The newly appointed relief cook (in training) is yet to undertake this course. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. There was evidence of sufficient emergency food for three days. The fridges, chillers and freezer temperatures are recorded and documented. All decanted food is dated, and expiry dates are recorded. Food in the fridges was dated and covered. The kitchen was clean and fit for purpose, there was a maintained kitchen cleaning roster, for all equipment. There was no food on the floor and hand washing equipment, gloves and hats were available. Chemicals are stored safely. The addition of three residents to the facility can be managed for the food service.
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	FA	If admission to a service is declined, prospective residents and their whānau are informed in an appropriate manner of the reasons why the service had been declined following the service policy. Where requested, assistance would be given to provide the declined resident and their whānau with other options for alternative health care arrangements or residential services. As confirmed at management interviews, entry to the service would be declined if the care level is not within the scope of the service or if a bed is not available.

appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The residents initial individualised care plan is created on admission using the NASC interRAI tool. Resident needs are identified through a variety of information sources including GPs, specialists, other service providers, the resident and family. The facility utilises assessment tools (falls, pain, pressure injury risk, weight, continence, and mood/behaviour). The residents' files also evidenced any completed discharge/transfer information from the district health board. The clinical files reviewed evidenced all residents had interRAI assessments and the long-term care plans completed within 21 days of their admission. The files reviewed showed the residents had current interRAI assessments completed by the trained RN interRAI assessor in the facility. There was evidence the results of the interRAI assessments were discussed with the residents and where appropriate the family. Interviews with residents and families confirmed they were involved in assessments, care planning, treatment, care plan evaluations and MDT reviews. Interviews with families and residents are held in a safe and appropriate setting and included visits from the GP and specialists.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans define the required support and interventions. Each resident has a Person-Centred Care Plan (PCCP) based on facility assessments carried out using an interRAI assessment tool. The residents' care plans are individualised, integrated and current. 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 or are carried over to the PCCP. In interviews, staff reported they receive timely and appropriate information for continuity of residents' care. The residents and/or families have input into their care planning and evaluation. Consistent GP care is completed, as sighted in current GP progress reports. Reviewed Care plans demonstrated service integration with progress notes. Resident activities records, and medical and allied health professionals' notations were clearly written in the resident files. There was evidence of allied health care professionals involved in the care of the residents including physiotherapist, podiatrist, and older person's community mental health team.
Standard 1.3.6: Service Delivery/Interventions	FA	When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file reviewed on the family communication form. Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessments, treatment and evaluation forms are available for use in the management of wounds. There were no wounds or pressure injuries on the day of audit. The service has access to wound nurse specialists. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Monitoring occurs for observations, blood sugar levels, pain and mood changes and challenging behaviour.
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 establish their individual interests and suitable activity and social requirements. An activity assessment and plan are completed on admission in consultation with the resident/family (as appropriate). The activities programme developed meets both individual and broader social needs of the residents. The planned monthly activities programme reviewed corresponded with the skills and interests shown in the residents' files. Activities are planned by a recreation officer and delivered from Monday to Friday. The recreation officer has been in this role since September 2020 and has a Diploma in Exercise Services, as well as currently undertaking New Zealand Quality Authority (NZQA) Level one and two healthcare assistant training. In interview, the recreation officer confirmed activities are voluntary for residents, but they are encouraged to attend. The activities programme reviewed meets the needs of the residents and include cognitive, social groups and one-on-one activities. Social 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. The activities coordinator confirmed the facility provides appropriate equipment. Daily exercises for all residents who wish to partake are overseen by the recreation officer inclusive of strength and balance based on the Otago Falls Prevention programme. There were current, individualised activities care plans in residents' files. Resident attendance was documented, and activities progress notes are recorded monthly by the activity coordinator. Activity requirements are evaluated as part of the formal six-monthly care plan review. Family/whānau and friends are welcome to attend all activities. Activities include (but not limited to); newspaper reading, reminiscing, board games, walks, arts and crafts and exercises. There are regular entertainers who attend in the weekends. Community

		visitors include church visitors and pet therapy visitors. There are visits into the community with Māori and non-Māori residents attending cultural events and there have been outings to the local heritage museum. The service has a van, and the recreation officer accompanies the residents on outings.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Reviewed files showed evaluations are documented, implemented and information is shared with residents and families. Formal care plan evaluations evidenced reassessments are measured to ascertain the degree of a resident's response in relation to desired outcomes. Reassessments are completed every six months using the interRAI assessments, or when a change in resident's health status occurs. Residents with health status changes had completed reassessments using interRAI. There was evidence of resident, family, health registered nurse, caregivers, recreation officer 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 at mandatory six-monthly intervals. The residents' progress notes are completed on each shift and there is evidence in reviewed files that residents' care is evaluated and reported on, if any change is noted it is reported to the RN (link CI 1.1.8.1). When a resident's progress is different than expected, the RN contacts the GP, or nurse specialist. A short-term care plan is initiated for short-term concerns, such as infections, wound care, changes in mobility and the resident's overall health or cognitive condition. Short-term care plans are reviewed by the RN daily, weekly or fortnightly as seen in the clinical files. Interviews with residents and family validated information sharing is timely and appropriate. The family are notified of any changes in resident's condition, three monthly GP reviews, and care plan evaluations, as confirmed at family interviews. There was evidence that care planning evaluations are documented and implemented. The resident's care plans were current and reviewed six-monthly.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability	FA	Files reviewed validated processes are in place to support resident's accessing or being referred to other health or disability services. There is evidence of an effective multidisciplinary approach to consultation, and this was seen in the clinical files reviewed. There was evidence of non-urgent and routine referrals in the resident files. Acute or urgent referrals are evidenced as being triaged immediately such as sending a resident to accident and

service providers is appropriately facilitated, or provided to meet consumer choice/needs.		emergency via ambulance. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
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 processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety datasheets are readily accessible for staff. Staff complete chemical safety training on orientation and the product supplier provides ongoing training in the safe use of chemicals. Chemicals are stored safely throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. A hazard register is available and is current.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	The building is two levels, with two resident rooms and a flat downstairs. The building has a current building warrant of fitness that expires June 2021. The owner oversees the maintenance programme. Staff use a maintenance and request form for repairs, which is signed off once addressed. There is a planned maintenance programme in place. Hot water temperatures are maintained below 45 degrees Celsius (monitored monthly by a contracted electrician). Essential contractors are available 24 hours. Electrical testing has been completed and calibration of medical equipment has been carried out. Environmental improvements include roofing repairs, two new heat pumps, refurbishment of the plumbing system and upgrading carpeting/flooring with improved lighting and heating in rooms. Improvement to stair rails, hall handrails and outside ramp for wheelchair access have also been undertaken since the last audit. Resident rooms are refurbished as they become vacant. The facility has corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade is provided. The caregivers interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And	FA	Communal toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are adequate numbers of communal bathrooms/toilets with a system that

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.		indicates if it is engaged or vacant. All shower and toilet facilities have call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and to promote independence. Residents interviewed stated their privacy is respected when staff are attending to their personal hygiene.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Residents and their families can personalise the resident's room. 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. 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. The two rooms requested to become double rooms (for the use of couples) have sufficient space to facilitate the use of a hoist. Observation and interviews with the manager confirmed that there was enough space to accommodate: personal items; furniture; equipment and staff as required. There is a new call system which can be easily made a dual system for two residents when required. The installation of privacy curtains is planned when required. The new room on the lower level, is of sufficient space to allow a resident to mobilise safely around furniture and equipment using a mobility aid. A call bell is installed and functional. There is adequate light (daylight), ventilation and heating. The one window in the room (of adequate size) is above shoulder level but does allow a view of plants and sky. The manager stated this room would be a choice for residents who request privacy from the main road or gardens. A request for reconfiguration of bed numbers has been made to the district health board and the Ministry of Health for the addition of three additional beds.
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	All internal communal areas have seating and external views. Communal areas within the facility include a main lounge and dining area. Seating and space is arranged to allow both individual and group activities to occur. All communal areas are easily accessible for residents using mobility aids. All furniture is safe and suitable for the residents. Observation and interviews with residents and family confirmed that residents can move freely around the facility and that the accommodation meets residents' needs. There are areas for storing activities equipment and resources.

		Most residents were observed to have their meals with other residents in the communal dining room but can have their meal in their own 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	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry and cleaning services. Facility laundry, including residents' personal clothing, is completed on site. There is a dedicated laundry/cleaner on duty seven days from 9.30 am to 12.30 pm. There are weekly task lists and spring-cleaning schedules to follow. 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 observation confirmed awareness of the need to keep the trolley with them at all times. Staff receive training in correct use of cleaning products. There is a sluice room available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility with alcohol gels in various locations. The laundry is located downstairs, and laundry is delivered through a chute. The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Residents interviewed reported satisfaction with the cleaning and laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. Emergencies and fire drills are included in the mandatory in-service. There is a sprinkler system installed throughout the facility and exit signage displayed. First aid training has been offered and all care staff have completed this training. The fire system has been upgraded and signed off by the fire service in March 2021. The service has sufficient food storage, water storage and alternative gas facilities for cooking in the event of a power failure/civil defence emergency. There is a battery backup system for emergency lighting. There are civil defence kits in the facility that are checked regularly. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. The facility is secured at night with call bell access afterhours and sensor lighting in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate	FA	Residents were provided with adequate natural light, safe ventilation, and heating. The service has installed thermostat-controlled heating wall panels in each resident room. There are heat pumps in communal areas. Bedrooms have external opening windows.

natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		On the day of the audit the external temperatures were noted to moderate, and the environment in resident areas was noted to be maintained at a satisfactory temperature.
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	Oceanview has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical nurse manager (registered nurse) is the designated infection control coordinator with support from all staff. The programme has a documented annual review.
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	There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising a supporting registered nurse and all staff) have good external support from the local IC nurse specialist at Midcentral DHB. The IC coordinator continues to update including undertaking a further DHB training course which included IC in March this year along with linking into zoom meetings/education. Resources are also accessed from the Ministry of Health, GP and a national business which provides policies/procedures and information on infection control. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. There was a good supply of equipment available should there be an outbreak.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated with additional information relating to Covid.

Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred on site along with online training. The infection control coordinator attends the infection control forums at the Midcentral DHB (zoom meetings in more recent times) and is provided with education and updates through this forum. The facility has undertaken two zoom audits via Midcentral DHB. They were on infection control and pandemic planning. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. There has been additional IC education for staff over the past year and on interview staff demonstrated a good understanding of minimising the risk of infection.
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	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. There was one gastric outbreak in July 2019 affecting four residents and lasting two days. Regional Public Health was informed, and advice was received and followed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had no residents using a restraint and there were no residents using an enabler. There had been no use of restraint and/or enablers for over two years. On interview staff demonstrated knowledge of what restraint is and that they focus on managing challenging behaviours. Education records evidenced that education on managing challenging behaviours is a regular topic.

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 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	There is a planned maintenance programme in place, and notifications of requests for repairs are actioned immediately or risk minimisation plans are set in place while awaiting trade services to attend. Shortfalls were identified around the building.	(i) Toilets and bathrooms have areas that are non-compliant with infection control standards. Surfaces must be free from cracks, peeling chrome (taps) to minimising microorganisms. (ii) One outside railing in a deck area is not within the height required for a safety barrier. (iii) Locks on windows when opened fully, could allow egress onto the roof, had not been maintained to working securely.	Ensure repairs are carried out and that these areas are scheduled as part of the routine maintenance plan. 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Example: A programme of staff education and development regarding progress note reporting has been carried out over the last year.	A programme of staff education and development regarding progress note reporting has been carried out over the last year. This involved care staff learning the importance of noting subtle changes for residents (physical and mental) and any changes that indicated an increase in frailty. The programme initiated a new style progress note form to assist staff in this process, and they were mentored through the use of developed guides relating to reporting on items such as, but not limited to, pain, gait, appetite, mood, sleeping pattern, confusion, agitation, weight loss/gain, shortness of breath, ankle swelling, activities of daily living and participation in activities. This programme has resulted in caregivers writing more individual resident progress notes relating to progress against goals or lack of, rather than generic notes. These notes are reviewed weekly or immediately if required by the RN and are used to assist with interRAI assessments, care planning

			and evaluations, ensuring changes are caught and improvements made to care much earlier. Thus, resulting in improved outcomes for residents, (e.g., residents being reviewed for walking frame or wheelchair adjustments/replacements to improve mobility, continence product re-evaluation for comfort and security and early referral to the GP or podiatrist)

End of the report.