

Oceania Care Company Limited - Redwood Rest Home and Village

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Oceania Care Company Limited

Premises audited: Redwood Rest Home and Village

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

Dates of audit: Start date: 27 January 2022 End date: 28 January 2022

Proposed changes to current services (if any): Redwood Lifestyle and Care Village is undertaking a site refurbishment, which commenced in 2021 and is being undertaken in two stages. Stage one is planned to be completed end of February 2022 and completion of the project is expected by the end of 2022/early 2023. Stage one has two new care suites, two rooms reconfigured into care suites and one reconfigured standard room. A new kitchen, two dining areas, a servery, sluice room, staff rooms and

temporary reception area. This will increase the number of dual-purpose beds to 37. The organisation has kept the Ministry and DHB informed of these changes.

Total beds occupied across all premises included in the audit on the first day of the audit: 30

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
Yellow	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
Red	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

Oceania Group owns and operates Redwood Rest Home and Village. The facility presently provides rest home and hospital level care for up to 30 residents, which can include younger people with physical and/or intellectual disabilities. The facility is managed by a business and care manager (BCM), supported by a clinical manager (CM), regional management (business, clinical and health and safety) and the centrally based national office staff. The organisation has system and processes in place to manage COVID-19 at all Ministry levels.

There have been no changes to senior staffing since the last audit. The facility has recommissioned three beds since the last audit and work continues on a major site refurbishment, in two phases. Phase one is near completion and was visited, as requested by the Ministry, as part of this audit. This area is planned to be ready for occupation on the 11 February 2022 and the full site redevelopment completed by the end of the year. The Ministry does not require a partial provisional audit at this stage only comments related to this stage and these are made throughout the report of the project. No issues were seen related to the phase one for occupancy by residents (five).

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the DHB. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a nurse practitioner. Residents and family members spoke positively of the care received.

Following a Health and Disability Commissioner complaint, the Ministry requested the auditors review the work on the recommendations made in the Commissioner's report. The organisation has undertaken considerable work in the identified areas and this audit identified that the recommendations were being met. Comment on the work is contained in the relevant areas of this report.

This audit has resulted in continuous improvement ratings in relation to staffing and medication management. No areas were identified as requiring improvement.

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.
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Residents and their families are provided with information about the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, gender, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Younger people with disabilities were able to express themselves freely. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

Few complaints are received for the service and a complaints register is maintained. Complaints were being resolved promptly and effectively.

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.		All standards applicable to this service fully attained with some standards exceeded.
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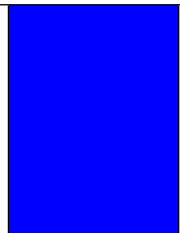
Business and quality and risk management plans included the scope, direction, goals, values and mission statement of the organisation. These include appropriate references to younger people with disabilities who are residents. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements were appropriate. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery to all residents and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

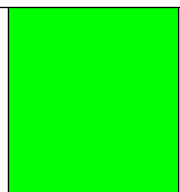
The multidisciplinary team, including a registered nurse and general practitioner or nurse practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information, and accommodate any new problems that might arise. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment


<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible and shade and seating were being provided. There are various areas provided for younger people with disabilities.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Personalised equipment for younger people with disabilities is well maintained and safely stored in their rooms, or nearby. Laundry is undertaken off site and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. The service's emergency plan considers the special needs of younger people with disabilities in an emergency. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

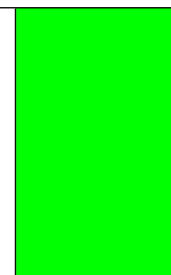
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Two enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests.

One resident had restraints in use for safety. A comprehensive assessment, approval and monitoring process with regular reviews occurs for all restraints. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed from the organisation's support office when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	2	48	0	0	0	0	0
Criteria	2	99	0	0	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Redwood Rest Home and Village has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is, provided by the clinical manager (CM), included as part of the orientation process for all staff employed and in ongoing training, as this was verified in training records (9 November 2021).</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Additional consents were sighted for COVID-19 vaccinations. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical manager (CM) confirmed that advocacy services had not been used but that when a complaint is lodged the response letter acknowledging it included information on how to contact the service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. All residents continue with their community general practitioner (GP) assisted by a nurse practitioner (NP) as the facility does not have a 'house doctor'. Some residents attend doctor appointments at the surgery if they are able.</p> <p>The facility currently has restricted visiting hours under the Ministry's COVID-19, red traffic light system. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Younger residents are encouraged to participate in community, use public transport and attend events promoting access to family and friends.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The Oceania complaints policy and compliment, suggestion, complaint form meet the requirements of Right 10 of the Code. The forms can be handed to the facility manager or put into the complaint's box in the reception area. Information on the complaint process is provided to residents and families as part of the 'welcome pack' on admission and those interviewed knew how to do so. High risk and external complaints, such as from the office of the Health and Disability Commissioner (HDC), are sent through the regional manager then onto the group general manager – clinical care services at Oceania's national office for management. There have been no external complaints, such as HDC complaints since the 2018 complaint. Review with the business care manager and clinical manager showed that all the recommendations from this HDC report have been actioned.</p> <p>The complaints register reviewed showed that 10 complaints have been received during 2021 and actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The business and care manager (BCM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided and discussion with staff. The Code is displayed in the hallway. Information on advocacy services, how to make a complaint and feedback forms are available at reception.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families, including younger people with disabilities (YPD), confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. There is one room that can accommodate a couple if requested.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and in clubs of their choosing, with appropriate opportunities for younger people with disabilities. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually (9 November 2021).</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Staff are able to support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice. The Māori Model of Care 'Te Whare Tapa Wha' guides staff in holistic care for Māori residents, though there were none at the time of audit. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, such as meal preferences, times for going to bed and getting up, and what activities they wished to attend. The resident satisfaction survey confirmed that individual needs are being</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>met.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct is signed when an employment offer is accepted. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care specialist, speech language therapist, and education of staff. The nurse practitioner (NP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Evidence based tools sighted in use included:</p> <ul style="list-style-type: none"> - The 'identify, situation, background, assessment and responsibility' (ISBAR) communication tool with external professionals. - The 'stop and watch' early warning tool. <p>Areas of good practice included the work on staff rostering to client needs (See criterion 1.2.8.1), my medication (See criterion 1.3.12.1.) and work on improving the kitchen operations. The kitchen reviewed its ordering of food products, planning and serving of meals with input from national and regional food managers. This saw weight gain of some residents and improvement in resident's satisfaction with Oceania as a provider. The project was Oceania's nominee at the New Zealand Aged Care Association's annual awards in the food category.</p> <p>Other examples include the investment in staff health, for example, a programme where if staff have pain they can be assessed by a physiotherapist and receive three free sessions of treatment. Staff report a good 'open door' philosophy of the management team with the changes that have occurred. The management daily brief 'stand-up' meeting to catch up, identify the challenges for the day and exchange information was reported to be very effective.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Oceania holds regular study days for registered nurses</p>

		(RNs) at a regional level.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this had not been required as all residents were able to speak English. Younger residents were able to express themselves without difficulty.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plan processes were reviewed in 2021, this included the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. Planning for younger people with disabilities is included in these strategies and reflected a person/family centred approach.</p> <p>There are monthly meetings with the regional managers (clinical and business) and BCM and clinical managers. From these meetings the regional managers reports to national office. Clinical indicators are electronic and available to regional and national managers. There is sufficient information to monitor performance being reported to national office, this includes, progress on the site redevelopment, financial performance, emerging risks and issues. Dashboards are developed for review and benchmarking with other facilities. Oceania also benchmark with similar national multisite aged care organisations.</p> <p>The service is managed by a BCM who holds relevant qualifications and business experience and has been in the role for three years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Oceania has a delegations policy. The BCM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through Oceania meetings, the Aged Care Association briefs, and meetings with the local DHB.</p> <p>The service holds contracts with the DHB for long term hospital level care (14 residents), rest home level care (16 residents) and respite care. A Ministry of Health contract for younger persons with disability (YPD) (two residents), one of whom is over 65 years of age. One is receiving hospital level care and the other rest home level care. There are twelve care suites/occupational rights agreements (ORA) with ten rest home level care and two hospital level care residents.</p>

<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>When the BCM is absent, the clinical manager (CM) carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management would be overseen by the clinical manager from another Oceania facility. The facility is grooming a senior RN to be able to take on the senior clinical responsibilities. Staff reported the current management is working well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes including clinical indicators, clinical incidents including infections and pressure injuries and staff incidents. A monthly quality audit schedule sighted, which details the percentage reached by each audit. When areas do not reach a threshold, reauditing occurs more frequently than scheduled. Younger people with disabilities (YPD) are encouraged to attend the monthly residents' meetings and complete the satisfaction surveys. Audits related to fluid balance charts as per requested by the HDC recommendations occurred. Ongoing any resident with an in-dwelling catheter is monitored by having a fluid balance chart started and this becomes part of the worklog for monitoring on a shift by shift basis. They can have input to quality improvements and one recently completed a complaints form. One YPD resident spoken with stated they felt they are included in decisions around personal technology, aids and equipment provided.</p> <p>There is an Oceania risk management process which including health and safety risks. A facility health and safety risk register was sighted and showed risks being identified through meetings, rated, mitigation strategies in place and review of risks ongoing at the health and safety meetings. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and related information is reported and discussed at the registered nurse, infection control, staff meetings, health and safety and quality improvement meetings. The management team meet each day for a verbal catch up on relevant issues and what is happening that day. Relevant corrective actions are developed, implemented and closed to address any shortfalls. Continual clinical improvement initiatives are identified using the 'plan, do, check and act' (PDCA) cycle to implement changes. Examples sighted included the Improvement of Care Outcomes at Redwood – Staff Wellness (See CI 1.2.8.1) and one related to medicine management (See CI 1.3.12.1).</p> <p>Staff reported their involvement in quality and risk management activities, the site redevelopment, and the continual clinical improvement projects as well as by attending meetings and being aware of changes to</p>

		<p>policies.</p> <p>Oceania wide policies and procedures are used at Redwood, with no local policies being used. These cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process with relevant NASC requirements for younger people. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff and equipment adverse and near miss events are recorded on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner.</p> <p>Patient incidents are recorded onto the electronic patient management system which translates to the clinical indicator programme. These records are available to regional and national office staff and allows for analysis, trending and benchmarking with other facilities. Dashboards are available to all management. Pressure injury monitoring is in place, including for residents with restraints. There were no pressure injuries reported in 2021 or to date 2022.</p> <p>The BCM described essential notification reporting requirements, including for pressure injuries, which RNs are made aware of. They advised there have been no notifications of significant events made to the Ministry of Health, DHB and no HDC complaints since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, validation of qualifications, the legal right to work in New Zealand, and practising certificates (APCs), where required. A sample of staff records reviewed (nine - the clinical manager, two RNs, cleaner, kitchen, chef, three health care assistants) confirmed the organisation's policies are being consistently implemented and records are maintained. All health professionals (nursing, general practitioners, podiatrist, dietitian, pharmacists) had a current APC.</p> <p>The clinical managers and RN job descriptions was reviewed as part of the review of recommendations from the 2018 HDC complaint. These detail the responsibilities of care clinical managers being: to ensure the provision of a high level of quality delivery and provide clinical leadership to clinical and care staff, ensuring Oceania Healthcare policies and procedures, contracted and audit requirements are maintained. The RN's responsibilities are to provide safe professional clinical care to Oceania Healthcare residents and a key responsibility is to ensure person centred care plans are kept up to date.</p>

		<p>Staff orientation includes an employee resource pack and orientation manual which includes all necessary components relevant to the role. Staff reported that the orientation process, including having a buddy, prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a year.</p> <p>Continuing education is planned on an annual basis, includes any issues identified the previous year, mandatory training requirements for all staff based on their role and their contractual requirements. Annual study days ('GEM') are held to cover these areas. An electronic training record is kept for each staff member, and this alerts the clinical manager when a staff member is due for re-training on mandatory training areas, such as first aid certificates. Care staff can also undertake medication competencies to assist RNs with medication rounds. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. All staff, with the exception of the kitchen staff, undertake first aid training. Healthcare assistants (HCA) are registered or commence New Zealand Qualification training within (NZQA) the first months of employment. The training levels identified for the HCAs were:</p> <p>Level 2 – 4 Level 3 – 6 Level 4a – 1 Level 4b – 5.</p> <p>A staff member is the internal assessor for the programme.</p> <p>All registered nurses are trained, competent and maintaining their annual competency requirements to undertake interRAI assessments.</p> <p>Records reviewed demonstrated completion of the required training as per the HDC recommendation and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>CI</p>	<p>There is an Oceania documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Redwood have undertaken a continual clinical improvement initiative with the outcome being to improve efficacy of staffing and quality of care utilising a resident acuity mix planner as well as ensuring staff wellness. A continual improvement rating has been awarded for this initiative. This initiative improves the process for adjusting staffing levels to meet the changing needs of residents.</p> <p>An afterhours on call rosters is covered by the BCM and clinical manager. At weekends there is also an on-call roster covered by senior RNs. Staff reported that good access to advice is available when needed.</p>

		<p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with the clinical manager working on the floor on three duties and the guest services manager, who is a trained health care assistance (HCA) also working on the floor on one occasion. Most short notice duty disruptions had been replaced by RNs and HCAs. There is 24/7 RN coverage in the hospital. There is a full complement of RNs. There were two HCAs and a cook vacancy at the time of audit, which were being advertised.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. This includes interRAI assessment information entered into the Momentum electronic database. Redwood uses an electronic system with each staff member having a unique password to maintain privacy and only have access to information pertinent to their scope of practice. Clinical notes were current and integrated with GP and allied health service provider notes either scanned in or through a personal log in. Records were legible with the name and designation of the person making the entry identifiable</p> <p>Archived records are held securely on site and are readily retrievable. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Prior to admission, prospective residents and family visit the facility and are provided with an admission information pack and discuss requirements of entry, such as having enduring power of attorney documentation in place. The regional clinical manager signs off on people purchasing the care suites while the BCM and CM discuss routine admissions to ensure residents' needs can be met safely. Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Relevant NASC assessments and authorisations for younger people with disabilities are complete. Residents purchasing a care suite (ORA) are not required to have a NASC assessment completed but it is recommended. The organisation seeks updated information from NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. A meeting is held with family members three weeks after admission to answer any questions and to sign the care plans and then every six months. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate.</p> <p>The service prints off a transfer document from the electronic system and uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. A resident confirmed that their family were provided with regular updates when they were admitted to hospital recently.</p> <p>All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>CI</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request and education has been provided for staff.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There is one resident who is self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. The resident interviewed was competent and safe storage was provided for medication.</p> <p>There is an implemented process for comprehensive analysis of any medication errors. In the year 2020, eighteen medication errors were reported. The problems were addressed in a continuous improvement</p>

		project resulting in a thirty five percent reduction in medication errors.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a qualified chef and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (31 March for winter menu and 6 October for summer menu). There were no recommendations made at this time.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Ministry of Primary Industries, current until March 2022. Food temperatures, including for high risk items, are monitored appropriately, and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. There is fruit provided for residents at any time. Special equipment, to meet residents' nutritional needs, is available. Residents with indwelling catheters have a fluid balance chart in use.</p> <p>A resident satisfaction survey in 2021 revealed a level of dissatisfaction with the food. Training was provided and an improvement made to presentation of meals resulting in a positive dining experience. Residents and family interviewed verified an improvement in the dining experience (refer standard 1.1.8). Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. This is guided by a preadmission risk assessment. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional assessment, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Plans for the YPD included meeting both community and educational needs as identified in NASC assessments, with one studying a foreign language and attending community events.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is consistently high. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. The YPD residents each had equipment to meet their specific needs.</p> <p>Monitoring charts are used for resident behaviour, turning charts, food and fluid intake for residents losing weight and all residents who have indwelling catheters have fluid balance charts in place. Residents with wounds have photos taken to record improvement alongside evaluation at each dressing change. Swabs are sent to the laboratory if infection is suspected.</p> <p>Care staff can read care plans and access a summary care plan that gives a detailed overview of residents' needs and abilities, to ensure consistent care. A health care assistant confirmed they read the care plans and a verbal handover each shift guides any urgent changes to care.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by an activities coordinator who is working on completing the diversional therapy training. Activities are provided Monday to Friday while activities, movies and family visits are arranged for the weekend.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated in response to engagement and as part of the formal six monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. A 2021 satisfaction survey showed some dissatisfaction with the programme. Time has been spent talking to the residents to ascertain their requirements and areas of interest. Managers are supporting the activities coordinator to improve the quality of the programme. Residents and family members interviewed confirmed they find the programme has some interesting activities and has been changing.</p> <p>Activities and social opportunities, both in the facility and in the community are made available for the YPD residents but they often choose to not attend saying they prefer to arrange their own social events. There is a specific activity on the calendar each week that relates to the under 65 year old residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN via a 'stop and watch' tool which the RN follows up before the completion of their shift.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating a short term care plan to evaluate the concern, before making changes to the long term care plan. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. Evaluation of pro re nata medication is entered into the medication system. When necessary, and for unresolved problems, LTCPs are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. The service does not have a 'house doctor', instead residents continue to deal with their own GP. This results in communication with thirty two GPs supported by a NP. If the need for other non-urgent services are indicated or requested, the GP, NP or RN sends a referral to seek specialist input. Copies of referrals were</p>

<p>External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>sighted in residents' files, including use of the ISBAR tool, to a speech language therapist and cardiac specialist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. No large volumes of chemicals are kept on site. An external company removes waste from the site twice a week or more regularly if required. The area used for the external storage of waste will move as part of phase one of the site development. The area designated for this was sighted and comment was made about it being close to the building and the need to ensure it is secured. A contracted chemical company supplies and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Spill kits are available.</p> <p>There is provision and availability of protective clothing and equipment, and staff were observed using these. There is sufficient personnel protective equipment, signage available in the event of any infectious outbreak and management by staff at the different Ministry COVID-19 levels.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 1 July 2022) was publicly displayed.</p> <p>The refurbishment project is going on around the present resident areas. Areas being worked on are blocked off to residents, internally and externally - this is being well managed. The planned completion of stage one (February 11 2022), will see five care suites for ORA occupancy available, increasing the bed numbers to 35. Some rooms are further advanced than others. Carpets and vinyl were still be put down in some of the rooms and electrical fittings were still to be put up and water connected to all the rooms. The new corridors have secured handrails. Residents spoken with raised no concerns related to this work and many enjoyed watching the external build.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The seal on the roadway at the entrance to the facility is now stones and this makes it difficult for residents to go out in their wheelchairs, electric and manual. There is another entrance which can be used, and management are aware of the issue and taking steps to ensure exit is managed safely and continue to promote residents' independence.</p>

		<p>The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free within the facility. The building has a few different levels with slopes between the different levels, which residents manage. Safety was promoted, with signage related to these slopes. Personalised equipment is available for the younger residents with disabilities to meet all their mobility and equipment needs.</p> <p>External areas are reduced presently, but there is sufficient space for residents to sit outside safely. These are maintained and were appropriate to the resident groups and setting. Younger people with disabilities can access all areas of the facility.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Each room has a wash-hand basin and all have an ensuite toilet and shower, including the five refurbished rooms. There are toilets available for staff and visitors presently and a new staff area will provide staff toilet and a shower room.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, including the refurbished care suites. One room presently has a ceiling hoist and four of the refurbished care suites will also have these installed. These plus other equipment, such as wheelchairs and walkers are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Some have the ability to be double, but none were being used as double during the audit. The site manager stated the new rooms were 33 square meters. No furniture was in these rooms to review the layout to allow movement. Present rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheelchairs and mobility scooters. One YPD resident keeps her aids, such as mobility scooter, in their room, the other had a wheelchair in their room and mobility scooter was being stored in an outside garage area. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>Communal areas are available for residents to engage in activities. Stage one completion will close the present dining/lounge area and two new dining/lounge areas will be created. The new dining and lounge</p>

<p>Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>areas are of different sizes. No furniture was in these rooms. Management of numbers will need to be explored to enable easy access for residents and staff.</p> <p>Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. New furniture will be used in the new care suites. Younger people with disabilities are catered for with use of internal and external areas. There is consideration of their compatibility with other residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken off site by an Oceania laundry facility in Nelson which is audited for compliance to the laundry standards. Rooms at Redwood are dedicated to the picking up of dirty laundry and a separate clean area for receiving the returned clean laundry, which is then distributed around the facility. New areas for these functions will be ready when stage one is completed (11 February 2022). Care staff are aware of the need for PPE when dealing with the removal of the dirty linen to the approved areas. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff undertake the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in lockable areas and were in appropriately labelled containers. Cleaning audits occur six monthly and corrective actions were sighted as being undertaken in relation to these.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Oceania have a comprehensive emergency management plan. There are also policies, guidelines, flip charts and grab bags for emergency planning, preparation and response. These were displayed and known to staff. Disaster, civil defence planning and COVID-19 guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of these emergency. These consider the special needs of younger people with disabilities.</p> <p>The site refurbishment has included changes to the fire evacuation plan, with the last plan being developed in October 2021, which is known to the New Zealand Fire Service. The plan will require to be redone again when phase one is completed (11 February 2022) and the BCM stated, this is being worked on presently. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in September 2021. The need to re-orientate staff to the new fire exits and evacuation plan is to occur after completion of phase one.</p> <p>Staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs were sighted and meet the National Emergency Management Agency</p>

		<p>recommendations for the region. Water is stored in bottles around the complex. In the event of power being damaged the local electricity provider will be contacted for assistance, there is emergency lighting from a bank of batteries and torches are available.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. The system alerts management if the call bell is not answered in a timely manner. Each new room and ensuite has a call bell installed but not yet connected to the system. The organisation is taking the opportunity to upgrade the call management system as part of the site redevelopment.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and doors that open onto the garden, as will the refurbished care suites. Resident's rooms and communal areas have heating provided by wall mounted air conditioning units and some have underfloor heating. All refurbished rooms will have wall mounted air-conditioning units installed.</p> <p>Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the organisation's support office. The infection control programme and manual are reviewed annually (11 August 2021).</p> <p>The clinical manager is the designated infection control (IC) nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the business care manager (BCM) and tabled at the quality/risk committee meeting. This committee includes the BCM, IC nurse, a RN, representatives from kitchen, housekeeping, the health and safety officer, and representatives from food services and maintenance.</p> <p>A QR code is available for scanning, and a health declaration form, masks and sanitiser were at the main entrance to the facility. Family members are required to make a booking to visit relatives and are required to produce a vaccine certificate under the Ministry COVID-19, red traffic light system. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>

		The refurbishment of the facility has been managed by national office. The regional manager confirmed there is clinical input provided via a development committee that meets monthly. Oceania Healthcare have an infection control specialist on staff and this person is consulted regularly regarding all aspect of service delivery and property development. The property development manager confirmed that all Oceania developments have air conditioning and positive pressure in corridors and common areas and the residents' rooms have negative pressure. Contractors on site for the refurbishment were observed meeting infection control protocols.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for over three years. They have undertaken an online training course in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit and the organisation's support office. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.
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	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in March 2020 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides	FA	Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by the IC coordinator.

<p>relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when there was an outbreak of respiratory illness.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and cough etiquette.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal and the upper and lower respiratory tract. The IC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality meeting and national support office. Data is benchmarked within the group and against the aged care sector. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a recent respiratory outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented. Another episode of a notifiable disease was handled appropriately.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Oceania restraint minimisation and safe practice policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. This was reviewed as a result of the HDC recommendations to include the need for ongoing monitoring of pressure injuries when restraint in use. The clinical manager is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. They demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>Oceania had a goal of being restraint free by 2021. On the day of audit, one resident was using restraints and two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint register, quality group minutes, files reviewed, and from interviews with staff and the two</p>

		residents with enablers.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Oceania policy details the approved restraints and enablers to be used and the restraint processes. The quality meeting reviews the use of restraints. There is clear accountability in the initiation of restraint use and detailed in the restraint register and in the quality meetings. All restraints used were those approved in the policy. Overall use of restraints is being monitored and analysed at a regional and national level.</p> <p>Evidence of EPOA involvement in the decision making was sighted on file of the one resident with the use of restraints.</p> <p>The use of a restraint or an enabler was part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. A RN/clinical manager undertakes the initial assessment with the clinical manager's involvement (as restraint coordinator), and input from the resident's EPOA. The clinical manager described the documentation process. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of resident who was using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised, and the clinical manager described how alternatives to restraints are discussed with staff and the EPOA, for example the use of sensor mats or low beds.</p> <p>When restraints are in use, two hourly monitoring occurs to ensure the resident remains safe, this includes pressure injuries and the policy notes this may be required more frequently for some residents. The electronic patient record lists/worklog records the time the restraint is put on and removed.</p> <p>A restraint register is maintained, updated and reviewed every month. The register was reviewed and contained the residents currently using a restraint and enough information to provide an auditable record.</p> <p>Staff have received training on the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>A review of the resident's file showed that the individual use of restraint is reviewed and evaluated during the three monthly care plan and interRAI reviews. There was evidence of the EPOA, being part of this review.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The national quality support manager and the facility clinical manager (in role of restraint coordinator), meet or 'ZOOM' regularly to review the organisation's overall restraint use. They review the restraints used and any areas of concern. The monthly clinical indicators included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families.</p> <p>The quality meeting reviews the facility restraint and enabler use at each meeting. Minutes of meetings reviewed confirmed this.</p> <p>An annual internal audit showed the facility meets the requirements of the standard and the organisation's policy as per the recommendation of the HDC following the 2018 complaint.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

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
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	CI	<p>In April 2021 the impact of the Redwood site redevelopment would see a reduction in resident numbers. Management undertook a project, the objectives of which were to streamline the clinical roster, optimise care delivery, provide fair allocations based on resident acuity mix, improve clinical indicators and deliver a positive impact to the wellbeing of clinical staff, as well as reduce financial liabilities for overtime, sick leave and annual leave. A ‘plan, do, check, act’ (PDSA) methodology documented showed the detail planning and implementation of this project.</p> <p>Measurements of the outcome of the project (measured from September 2021 to January 2022) results showed:</p> <p>Care Outcomes:</p> <ul style="list-style-type: none"> Efficiency on the floor – cares are completed earlier in the mornings and increase of approximately 75 percent attendance at morning tea. 	<p>The Redwood site re-development saw the number of residents being reduced during the period of redevelopment. Staff took the opportunity to review the rosters of staff. This was done in a planned way with staff, management, and union involvement. A ‘PDSA’ project management process was undertaken which took into account areas which could be improved, such as improve clinical indicators (for example falls, pressure injuries, issues with staff, such as team dynamics and financial imperatives, for example, high sick and annual leave). The new approach, saw the development of skills improvement and introduced a skills mix philosophy to rostering for all clinical staff including RNs.</p> <p>This work has seen an improvement in all areas identified and has seen the development of tools for</p>

	<ul style="list-style-type: none"> • Improved clinical indicators seeing a reduction in clinical incidents overall. The facility dashboard shows a reduction in falls and wounds (September - 10 falls (five in hospital and rest home) and in December six falls (two in hospital and four in rest home). For wounds - September 36 and in December 18. • Well embedded process for the review of resident acuity and staff skill mix and allocations. • The tools developed to measure HCA competencies and resident acuity against allocations are now used by other Oceania Care Homes including when reviewing rosters. • The medication competency HCA position is part of the ongoing rosters providing better support for RNs during medication rounds (second checker) and in management of the duty. This was reported to be working well. • Moving the morning and afternoon tea rounds into the duties of the kitchen assistants, providing more time for HCAs to provide cares. <p>Staff Wellness</p> <ul style="list-style-type: none"> • All staff have been moved to a '4 on 4 off' roster to enable better teamwork and rest. • A leave planning methodology is in place for all staff, evidenced by a reduction in high leave balances and leave liability costs as a metric for staff wellness. (Reduction in leave liability by 1792 hours over seven months. July 2021 - 8050 hours, January 2022 - 6,258 hours). A potential saving of \$44,800.00 over the period. • Sick leave as a percentage of gross wage has reduced from an average of around 2.8% over 2020 to 1.8% in January 2022, with Redwood – this shifted Redwood from the 'red' to the 'green' category benchmarked against other Oceania sites. (Sick leave and overtime metrics have improved, indicating that this is working well) <p>Overtime as a percentage of Gross Wage has reduced from an average of 1.8% over 2020 to 1.1% in December 2022 - this</p>	<p>assessing resident acuity against staff skill mix to ensure better outcomes for the residents. The tools have been used by other Oceania facility to review staffing and roster development.</p>
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		<p>shifted Redwood from the 'red' to the 'green' category benchmarked against other Oceania sites.</p> <ul style="list-style-type: none"> • Staff understand the methodology and are more aware of the importance of metrics and measurement to assess care needs and solve day to day problems. • A general sense of improvement in staff morale – hearing laughter and genuine banter between staff and residents; positive sentiment towards management; positive perceptions amongst families of the changes made as evidenced in this report. • Four RNs have been put through the 'Level Up' process leading to improved potential for retention. <p>The new approach, saw the development of skills improvement and introduce skills mix philosophy to rostering for all clinical staff including RNs.</p> <p>Considerations included the historical high sick leave and overtime rates of staff and accrued leave liability. Team dynamics were not always conducive to a culture of cohesion and good teamwork.</p>	
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in</p>	<p>CI</p>	<p>Over the year 2020, eighteen medication errors were reported. Investigation revealed that the thirty two GPs used by residents were charting medications at different times resulting in ongoing medication rounds. This, combined with a small medication room, meant staff could not see which medications needed to be reordered. The CM engaged with the GPs and got them to streamline charting to decrease the number of rounds. The medication room was revamped to enable staff to see clearly what stock needed to be reordered. Competencies were refreshed and extra training provided where needed. Health care assistants were educated to not interrupt the round and took over answering the phone. Photo identification was included in the trolley. At change of shift the two RNs physically check the trolley together to ensure all medications are given.</p>	<p>A quality improvement project to reduce the rate of medication errors was implemented and resulted in a decrease of medication errors from eighteen in 2020 to zero in 2021. This included staff competencies related to medication management being assessed and training occurred as necessary. Medication rounds became more efficient due to agreed medication administration times and medication trolley checking.</p>

order to comply with legislation, protocols, and guidelines.			
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End of the report.