

Oceania Care Company Limited - Addington Lifestyle 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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Oceania Care Company Limited
Premises audited:	Addington Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 11 July 2017 End date: 12 July 2017
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	95

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
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

Addington Lifestyle Care (Oceania Healthcare Limited) can provide care for up to 97 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. Occupancy on the day of the audit was 95. The service provides rest home, hospital and dementia level care.

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

The business and care manager is responsible for the overall management of the facility and is supported by the regional and executive management team. Service delivery is monitored.

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.	Green	Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible in information packs and displayed within the service. Residents and family members confirmed they are informed and their rights are met, staff are respectful of their needs and communication and feedback is appropriate.

Residents, families and enduring power of attorney are provided with information required prior to giving informed consent. Time is provided if any discussions and explanation are required relating to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

A complaints register is maintained. Complaints are managed as per timeframes in the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights.

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.
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Oceania Healthcare Limited is the governing body and is responsible for the service provided at Addington Lifestyle Care. The business and care manager is a registered nurse, holds a current practicing certificate, and is qualified and experienced in management systems and processes. The clinical manager is new to the role and is supported by the clinical and quality manager (regional), the operations manager (regional) and the senior clinical and quality manager (national) regarding oversight of clinical care.

Oceania Healthcare Limited has a documented quality and risk management system that supports the provision of clinical care at the service. Policies are reviewed at support office and are current. Quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status reports. Benchmarking reports are

produced that include incidents/accidents, infections, complaints and clinical indicators. Resident information is identifiable, accurately recorded, current, confidential, accessible when required and securely stored.

There are human resource policies implemented around recruitment, selection, orientation, staff training and development. Staff, residents and family confirmed that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The organisation works closely with the local Needs Assessment and Service Coordination Service and health services for older people at the district health board. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team within the required timeframes on admission. There are registered nurses on duty 24 hours a day in the facility. Registered nurses are supported by the clinical manager, healthcare assistants and allied health staff, including the physiotherapist, pharmacist, podiatrist and two contracted general practitioners. On-call arrangements for support from senior staff are in place and after hours general practitioner cover is available. Shift handovers and communication handover sheets guide continuity of care and service provision.

The person centred care plans are individualised, based on a comprehensive and integrated range of clinical information. Short-term care plans are developed to manage any new problems that might arise. All residents' records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in the evaluations and care planning, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate handovers.

The planned activity programme is delivered by two activities coordinators. The staff provide residents with a variety of activities and group activities and maintains and promotes their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, and meets food safety standards. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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All building and plant comply with legislation, with a current building warrant of fitness in place. The environment is appropriate to the needs of the residents. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents are provided with accessible and safe external areas. Residents' rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Essential emergency and security systems are in place and fire drills are completed every six months. Call bells are available to all residents and are monitored monthly.

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. Four enabler and four restraints are in use at the time of the audit. Restraint is only used as a last resort. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive education at orientation/induction to the service and annually. Education includes all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult and challenging behaviours. Staff interviewed 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.
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The infection prevention and control programme is led by an experienced infection control nurse who has attended relevant training for this role. The policies and procedures have been reviewed and terms of reference have been updated to guide staff. The infection control committee meets monthly. Specialist infection prevention and control advice is able to be accessed from the district health board; microbiologist; infectious disease physicians and other experts as required. The infection prevention and control programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided and supported by reference to the infection control manual. Regular education is provided.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	101	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 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, with infection prevention definitions reflecting a focus on symptoms rather than laboratory results. The infection control nurse interviewed reported the following is included in surveillance for example, urinary tract infections, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and other skin conditions. When an infection is identified, a record of this is documented on the infection reporting form used by the service provider. The infection control nurse reviews all of the reported infections. Monthly data is collated and analysed to identify any trends, positive causative factors and required actions. All results of surveillance are reported to the clinical manager for the monthly key performance indicator reporting to support office management team.</p> <p>The results of surveillance are shared with staff via staff meetings (minutes sighted) and at staff handovers. Handover was observed in the hospital between shifts and examples of infection prevention and control issues were explained by the registered nurse providing the handover to ensure early intervention occurs. Graphs are produced that identify trends for the current year and a summary is documented. Data is benchmarked with other services in the organisation and this provides assurance that infection rates in the facility are below average for the sector.</p>

<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Residents confirmed that they receive services that meet their needs and they receive information relative to their needs. Staff receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme.</p> <p>All staff have had training in the Code during the previous 12 months and interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice including: maintaining residents' privacy; informed consent; giving residents choices; encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.</p> <p>The auditors noted courteous and polite attitudes towards residents on the days of the audit.</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>	<p>FA</p>	<p>There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent. Resident files identified informed consent is obtained. Interviews with staff confirmed their understanding of informed consent processes. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.</p> <p>Service information pack includes information regarding informed consent. The BCM and CM discuss informed consent processes with residents and their families during the admission process. The policy and procedure includes guidelines for consent for resuscitation/advance directives. Resuscitation orders are completed for residents when applicable.</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>Resident information relating to advocacy services is available at the entrance to the facility and in information packs provided to residents and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Staff training regarding advocacy services was last provided in 2017 and as a component of the Oceania annual 'grow, educate and motivate' (GEM) training programme.</p> <p>The health and disability advocate visits the service, as confirmed by the management team. Family and residents confirmed the service provides opportunities for the family/EPOA to be involved in decisions and they state they are informed about advocacy services. Family members in the dementia unit confirmed they act as advocates for their family member and also for other residents if they identify any needs.</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>The service has an open visiting policy and residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families confirmed they could visit at any time and are always made to feel welcome.</p> <p>Residents are encouraged to be involved in community activities and to maintain family and friend networks. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments.</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 organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved.</p> <p>Evidence relating to each lodged complaint is held in the complaints folder and register. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner. Staff, residents and family confirmed they knew the complaints process.</p> <p>The BCM is responsible for managing complaints and residents and family stated that these are dealt with as soon as they are identified. Residents and family members were able to describe their rights and advocacy services particularly in relation to the complaints process.</p> <p>There has been one complaint lodged with the Christchurch District Health Board which has been closed out. There have been no complaints lodged with the Health and Disability Commissioner or any other external authorities since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The business and care manager (BCM) and the clinical manager (CM) discuss the Code with residents and their family on admission. Discussion relating to the Code is included on the agenda and discussed at the residents' meetings.</p> <p>Resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. The posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	<p>FA</p>	<p>Addington Lifestyle Care has a philosophy that promotes dignity, respect and quality of life. The service ensures that each resident has the right to privacy and dignity. The residents' personal belongings are</p>

<p>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>used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings.</p> <p>Resident files reviewed confirmed that cultural and/or spiritual values and individual preferences are identified.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident.</p> <p>Healthcare assistants report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families confirmed that residents' privacy is respected.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports or on the incidents reviewed in residents' files. Residents, staff, family and the general practitioner confirmed there was no evidence of abuse or neglect. Staff confirmed they are aware of the need to ensure residents are not exploited, neglected or abused. Staff can describe the process for escalating any issues.</p> <p>Resident files reviewed confirmed that cultural and/or spiritual values and individual preferences are identified.</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>The organisation has a cultural responsiveness policy which outlines the processes for working with people from other cultures. A Māori health plan outlines how to work with Māori and the relevance of the Treaty of Waitangi. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan.</p> <p>A review of residents' files confirmed that specific cultural needs are identified in the residents' care plans. The BCM stated that a kaumātua can be accessed by the service to support staff on tikanga protocols and general advice via the Christchurch District Health Board. Staff are aware of the importance of whānau in the delivery of care for the Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally</p>	<p>FA</p>	<p>Residents and family are involved in the assessment and the care planning processes. Staff and resident interviews confirmed there are choices for residents regarding their care and services. Information gathered during assessment includes the resident's cultural values and beliefs. The initial care plan, the long-term care plan and interRAI assessment are based on this information.</p>

safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		Staff are familiar with how translating and interpreting services can be accessed. Residents in the service did not require interpreting services on audit days.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Addington Lifestyle Care implements the Oceania Healthcare Limited (Oceania) policies and procedures based on good practice, current legislation and guidelines. Staff training includes discussion of the staff code of conduct and prevention of inappropriate care. Interviews confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. There were no complaints recorded in the complaints register for the previous 12 months relating any form of discrimination.</p> <p>Job descriptions outline the responsibilities of position, including ethical issues relevant to the role. Staff complete orientation and induction which includes recognition of discrimination, abuse and neglect. Staff confirmed their understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service implements Oceania policies to guide practice. The policies align with the Health and Disability Services Standards.</p> <p>The organisation's quality framework includes their internal audit programme. Benchmarking occurs across all the Oceania facilities. There is a training programme for all staff and managers are encouraged to complete management training.</p> <p>Residents and families expressed a high level of satisfaction with the care delivered.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/EPOA of any accident/incident that occurs.</p> <p>Procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident/accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms. Family confirmed they are invited to the care planning meetings for their family member and can attend the residents' meetings. Families confirmed they are well informed. Family contact is recorded in residents' files.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. The admission agreements reviewed were signed on the day of admission. Family of residents in the dementia unit state they can raise any issues on behalf of their family member and believe these are followed up promptly.</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>	<p>FA</p>	<p>Addington Lifestyle Care is part of the Oceania Healthcare Limited (Oceania) with the executive management team providing support to the service. Communication between the service and managers occurs monthly with the clinical and quality manager providing support during the audit. The monthly business status report provides the executive management with progress against identified indicators.</p> <p>The organisation's mission statement and philosophy are displayed at the entrance to the facility. Information in booklets are given to new residents and staff training is provided annually.</p> <p>The service has a business and care manager (BCM) supported by a clinical manager (CM). The BCM has been in the role for four years .The CM has been in the position for five weeks, holds a current annual practising certificate and is supported by the clinical and quality manager (CQM). The management team is well supported in their roles and have completed appropriate induction and orientation to their roles. The facility can provide care for up to 97 residents for rest home, hospital, dementia, young people with disability and respite care.</p> <p>On the first day of audit there were 95 residents living at the facility including 25 residents requiring rest home level of care, 42 residents requiring hospital level of care and 28 requiring dementia level care.</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>During a temporary absence of the BCM, the CM is responsible for the day to day operation of the service and is supported by a senior registered nurse, the regional CQM and the regional operations manager. In the absence of the CM, the BCM with the support and help of the regional CQM, ensures continuity of clinical services.</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</p>	<p>FA</p>	<p>Addington Lifestyle Care uses the Oceania Healthcare Limited (Oceania) quality and risk management framework that is documented to guide practice.</p> <p>Oceania organisational policies and procedures are available to staff and guide service delivery. The policies and procedures are relevant to the scope and complexity of the service; reflect current accepted good practice, and reference legislative requirements. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies are presented to staff to read and sign to evidence they have read and understood the policy. Staff confirm they are advised of updated</p>

<p>principles.</p>		<p>policies and those policies and procedures provide appropriate guidance for service delivery.</p> <p>The service delivery is monitored through number of clinical indicators such as: complaints; incidents and accidents; surveillance of infections; pressure injuries; falls; medication errors and implementation of an internal audit programme. Completed audits for 2016 and 2017, clinical indicators and quality improvement data is recorded on various registers and forms. Quality improvement data provides evidence that data is being collected, collated and analysed to identify trends. Where required, corrective action plans are developed, implemented and evaluated.</p> <p>There is communication with all staff, residents and family through the facility's meetings. Staff meetings evidence all aspects of quality improvement, risk management and clinical indicators are discussed. Staff report that they are kept informed of quality improvements. Copies of meeting minutes are available for review for staff unable to attend the meeting.</p> <p>The satisfaction survey for family and residents in 2017 shows they are satisfied with services provided and this was confirmed by residents and family interviewed.</p> <p>Health and safety policies and procedures are documented along with a hazard management programme. There is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk.</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>	<p>FA</p>	<p>The BCM is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police attending the facility, sentinel events, infectious disease outbreaks and changes in key management roles. Evidence was sighted confirming that the Ministry of Health had been notified of the new CM appointment.</p> <p>Staff interviews and review of documentation evidence that staff document adverse, unplanned or untoward events on an accident/incident form which are signed off by the BCM. There have been no deaths referred to the coroner or essential notifications to Ministry of Health and district health board since the last 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</p>	<p>FA</p>	<p>Policies and procedures in relation to human resource management are available and implemented. The skills and knowledge required for each position is documented in job descriptions. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.</p> <p>The organisation has a mandatory education and training programme with an annual training schedule</p>

<p>the requirements of legislation.</p>		<p>documented. Staff are also supported to complete education via external education providers. Staff have completed training around pressure injuries in 2016 and 2017. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided. Nine registered nurses have completed interRAI assessments training and competencies. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to demonstrate competency on a number of tasks, including personal cares. The staff orientation covers the essential components of the service provided. Healthcare assistants confirm their role in supporting and buddying new staff.</p> <p>Annual competencies are required to be completed by clinical staff. There was evidence in the clinical staff files reviewed of competencies relating to: hoists; oxygen use; hand washing; wound management; medication management; moving and handling; restraint; nebuliser; blood sugar level testing; insulin administration; and assisting residents to shower.</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>FA</p>	<p>The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.</p> <p>There are 83 staff, including the management team, clinical staff, a diversional therapist, and household staff. There is always a registered nurse on each shift. The BCM and CM are on call after hours. Residents and families confirmed staffing is adequate to meet the residents' needs.</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>	<p>FA</p>	<p>There are policies and procedures in place for privacy and confidentiality of residents' records. Relevant resident care documentation can be accessed in a timely manner. The service retains relevant and appropriate information to identify residents and track records. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Archived records are securely stored and easily retrievable.</p> <p>All components of the residents' records reviewed include the residents' unique identifiers. The clinical records are integrated and include information such as medical notes, assessment information and reports from other health professionals. Medication charts are kept separate from residents' files. Resident files and medication charts are accessed by authorised personnel only.</p> <p>Residents' progress notes are completed on every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes</p>

		identify the name and designation of the person making the entry.
<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>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. This was verified with copies of the authority and approval being kept in each resident's individual record reviewed. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the business and care manager (BCM). This was observed during the audit. The residents/family/representative are also provided with written information about the service and the admission process. The organisation seeks updates and information from the NASC Service and/or the general practitioner 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. Resident records reviewed contained demographic detail and assessments completed. Signed and dated resident admission agreements are held separately as per Oceania policy in the BCM's office and are locked in a filing cabinet. Legislative and contractual requirements are met.</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>	FA	<p>The services uses the DHBs 'yellow envelope' system to facilitate a transfer to the DHB to and from acute services. An escort is arranged as necessary. A copy of the medication record and the information record of the resident is also included in the envelope at the time of transfer. Exit, discharge or transfer is managed in a planned and coordinated manner by the registered nurses. The GP commented during interview on this process and was satisfied with the care provided by staff. Staff demonstrated open communication between all services, the resident and the family.</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>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>The service is using an electronic medication management system which was observed in the dementia unit on the day of the audit. The staff observed demonstrated knowledge and a clear understanding of the role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medication is supplied from a contracted pharmacy in a pre-packaged format. These medications are checked by the receiving registered nurses in each service, against the prescription. Clinical pharmacy audits are performed six monthly by the contracted pharmacy. No medications sighted were out of date.</p>

		<p>A system for return of medicines to pharmacy is in place.</p> <p>Drugs are stored securely in the hospital in accordance with requirements. The drugs are checked weekly by two registered nurses where appropriate and this documented in red ink in the drug register reviewed. Six month stock checks are completed and a stamp is used to verify this check and balances are correct.</p> <p>The medicine fridges are checked and temperatures are recorded daily. Temperatures were within the recommended range.</p> <p>The electronic system is password access only. All allergies are documented in red or any other alerts as required. The three monthly review is consistently recorded and this was verified in the sample of residents medication records reviewed. Prescribing in line with best practice was noted, including the management for pro re nata (PRN) medicines.</p> <p>There are no residents who self-administer medications at the time of the audit. Appropriate processes are in place to ensure this is managed in a safe manner, should it be needed.</p> <p>Medication errors are reported to the clinical manager and recorded on an incident form as per protocol. The resident and/or the designated representative would be advised should an error occur. There is a process for comprehensive analysis of any medication errors and compliance with this process was verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food service operations policies, guidelines and appendices were current. Job descriptions for the executive chef and assistants are clearly documented in the manual to guide staff. The food service is provided on site by the executive chef and kitchen team and is in line with recognised nutritional guidelines for older people. The menu is reviewed by the organisation's national dietitian and this has been completed in the last two years. Any recommendations made at the time have been implemented. The service has a summer and winter menu. The daily menu is documented on the whiteboard in the dining rooms in each service areas. Special events are catered for such as the 'mid-winter Christmas lunch' on the day of the audit.</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. Food temperatures, including high risk items, are monitored appropriately and recorded as part of the plan. The executive chef and eight of ten staff have completed all food safety and hand hygiene requirements including NZQA recognised qualifications. The two staff who have not completed the food safety course have recently been employed and have completed orientation for working in the kitchen. Certificates are displayed on the</p>

		<p>kitchen education board.</p> <p>The registered nurses perform a nutritional assessment for each resident on admission to the facility and a dietary profile is developed. A copy is given to the executive chef and a copy is retained in the resident's individual record. The personal preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment and resources to meet resident's nutritional needs is readily available.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure assistance is available to residents as needed. Resident satisfaction with meals was evidenced in the resident/family satisfaction survey completed annually and confirmed during interviews with the executive chef, activities coordinators, residents and family members.</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 at the time, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. When the needs of a resident change, a referral for reassessment to the NASC is made and a new placement found in consultation with the resident and whānau/family. 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>	FA	<p>Information is documented using validated recognised nursing assessment tools such as the Abbey Pain Scale, Braden Scale, fall risk, skin integrity, nutritional screening and nutritional supplement screening and depression scale as means to identify any deficits and to inform care planning. The sample of PCCPs reviewed have an integrated range of resident related information. All residents have current interRAI assessments completed by one of nine registered nurses who are trained interRAI assessors on site.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident PCCPs reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. The PCCPs evidence service integration with the progress records, activities records, medical and allied health professional's notations clearly documented, informative and relevant. Any change in care required is documented and verbally passed on to staff concerned. Resident and families reported participation in the development and ongoing evaluation of the care plans. The PCCPs are signed by family/resident and staff who have assisted in</p>

		the care of the resident, for example, the activities coordinator, the physiotherapist, healthcare assistant and the registered nurse evaluating the plans.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care 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 GP interviewed, verified medical input is sought in a timely manner, medical orders are followed, and care is well managed. Registered nurses and healthcare assistants interviewed confirmed that care was provided as outlined in the documentation. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' identified needs.</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>	FA	<p>The activities programme is provided currently by two activities coordinators. A diversional therapist has been employed and will be commencing the role as per the roster sighted. The activities coordinators interviewed discussed the recreational assessment which is completed when residents are admitted. The purpose of the recreational assessment is to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme/calendar that is meaningful to the residents. The residents' activity needs are evaluated six monthly or more often if required.</p> <p>The planned weekly activities calendar sighted matches the skills, likes, dislikes and interests identified in the assessment information. The activities calendars are displayed in all services and residents receive a copy as well. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group and one-on-one activities are offered across all services. Examples include craft activities, exercises to music, housie, newspaper reading, happy hour and sing-a-long sessions. External outings in the community are offered. Entertainment and visitors from the community make up a significant part of the activities programme reviewed.</p> <p>Resident meetings are held regularly and residents' input is sought and responded to. Resident and family surveys demonstrated satisfaction with the programme and confirmed information is used to improve the range of activities offered. Residents interviewed stated they find the programme fun and interesting.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the individual people living there. Activities are offered at times when residents are most physically active and/or restless. This is reflective on the 24 hour assessment wheel utilised. Adequate resources are provided by the activities coordinators to meet the needs of individual residents. The activities programme for the dementia unit had been signed off by the previous diversional therapist before they resigned from this</p>

		service.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress records. The healthcare assistants interviewed understood about reporting any changes observed to the registered nurse or the clinical manager.</p> <p>Formal care evaluations occur six monthly in conjunction with the six monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the registered nurse. Where progress is different than expected, the service responds by initiating changes to the PCCP. Short-term care plans were reviewed as clinically indicated and examples of short term care plans being implemented were for infections, pressure injury and wound care management. According to the degree of risk noted during the assessment process, these plans are evaluated daily, weekly or fortnightly. 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 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>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. There are two resident doctors but residents may choose to use another medical practitioner. The GP interviewed discussed the referral process and as required sends a referral to seek specialist input as required for a resident. Copies of referrals were reviewed in resident's records, including referrals to inpatient services at the DHB, renal specialists, radiology, outpatient clinics and other services. The GP commented that the response to referrals at the DHB is positive and the DHB responses are received in a timely manner. Referrals are followed up as required and any appointments are noted in the communication books in each service area. The resident and family are kept well informed of the referral process. Any acute/urgent referrals are attended to immediately, such as sending a 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</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirements for labels to be clear, accessible to read and free from damage.</p> <p>Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education in safe and appropriate handling of waste and hazardous substances.</p>

service delivery.		There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas. Chemicals are stored in a designated shed with chemical hazard signs.
<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>	FA	<p>A current building warrant of fitness is displayed. There have been no building modifications since the last audit, although there has been refurbishment of the facility as part of the Oceania's facilities upgrade programme, including an upgrade to the kitchen and one of the garden courtyards.</p> <p>There is a planned and reactive maintenance schedule implemented. The service has an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually. Interviews with staff and observation of the facility confirmed there is adequate equipment.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are three internal courtyards and lawns, areas with shade and outdoor table and chairs. The external areas are maintained and appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. Residents confirm they are able to move freely in and around the facility and that the accommodation meets their needs.</p> <p>The secure unit for residents with dementia has one entrance with key pad access internally and one exit into a secure courtyard.</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>All residents' rooms have an en suite bathroom. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are maintained at a safe temperature.</p> <p>Communal toilets have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</p> <p>Auditors observed residents being supported to access communal toilets and showers, in ways that are respectful and dignified.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with</p>	FA	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Equipment was sighted in rooms with sufficient space for the equipment, staff and the resident.</p>

adequate personal space/bed areas appropriate to the consumer group and setting.		Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own. There are designated areas to store mobility aids, hoists and wheelchairs.
<p>Standard 1.4.5: Communal Areas For Entertainment, 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>	FA	<p>The service has lounge/dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>The dining areas have ample space for residents. Residents can choose to have their meals in their room. The dementia unit has its own dining room and lounge area, with residents in the dementia unit encouraged to join in some activities held in the main hospital/rest home area.</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>Cleaning and laundry policies and procedures are documented and implemented.</p> <p>Linen service is conducted at another Oceania facility. There are processes in place for collection, transportation and delivery of linen and residents' personal clothing. The effectiveness of the cleaning and laundry services is audited via the internal audit programme. The cleaner was able to articulate the cleaning processes in line with policy during interview.</p> <p>There are safe and secure storage areas, and staff have appropriate and adequate access to these areas as required. Chemicals are labelled and stored safely within these areas. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility.</p> <p>Residents and families stated they were satisfied with the cleaning service. The business and care manager stated there are areas requiring improvement around the laundry service and corrective actions are in place.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	FA	<p>Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification are available.</p> <p>A New Zealand Fire Service letter approving the fire evacuation scheme dated 2013 was sighted. Trial evacuations are held six monthly. Emergency and security management education is provided at orientation and as part of the in-service education programme. Information in relation to emergency and security situations is readily available/displayed for staff and residents. The emergency equipment is</p>

situations.		<p>accessible, stored correctly, current and stocked to a level appropriate to the service setting.</p> <p>There is a call bell system in place that is used by the residents, family and staff members to summon assistance, when required. Call bells are available in all resident areas. Call bells are monitored by the maintenance staff monthly. Residents confirmed they have a call bell system in place, which is accessible and staff respond to it in a timely manner.</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>Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There are safe designated smoking areas for the staff and residents.</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 provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. The organisation has a comprehensive and current infection prevention and control manual which was reviewed in March 2017 and is available to guide staff. The infection control programme and manual are reviewed annually.</p> <p>A registered nurse is the designated infection control nurse, whose role and responsibilities are defined in a job description. All infection control matters, including surveillance results, are reported monthly to the clinical manager and tabled at the quality and staff meetings. The infection prevention and control committee includes the infection control nurse and representatives from all service areas.</p> <p>IPC signage is used at the main entrance to the facility as required especially in the winter months or if there is an infection outbreak at the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they are unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	FA	<p>The infection control nurse has appropriate skills, knowledge and qualifications for the role, and been in this role for one year. The infection control nurse has attended relevant study days and has completed the Ministry of Health online infection prevention and control training and the certificate was sighted. Well established local networks with the infection control team at the DHB are available as well as expert advice from the local laboratory and GP if required. The infection control nurse has access to</p>

<p>infection control programme and meet the needs of the organisation.</p>		<p>residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection control nurse confirmed the availability of resources to support the programme and manage any outbreak of an infection. There have been no infection outbreaks since the last audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed March 2017 and include appropriate referencing. Staff were observed following organisational policies such as use of appropriate hand sanitizers, good hand-washing techniques and use of disposable personal protective equipment such as gloves, aprons and hats appropriate for the setting. Hand washing and sanitizer dispensers are readily available around the facility in all areas of service provision. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation/induction and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control nurse. The infection control nurse reported that one of the infection control nurse specialists from the DHB provides education on a regular basis for staff and oversees this facility as part of the community service provided by the DHB. Content of the training is documented and attendance records are maintained. The training is evaluated to ensure it is relevant, current and understood.</p> <p>Education with residents is generally on a one-on-one basis and has included reminders mostly about hand washing or advice about staying in their own room if they are unwell.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint minimisation management in the facility. The restraint coordinator attended training as evidenced by certificates in the restraint manual. The clinical manager, a senior registered nurse and the quality care manager for the service were interviewed and</p>

<p>minimised.</p>		<p>demonstrated a sound understanding of the organisation's policies, procedures and practice, roles and responsibilities.</p> <p>On the day of the audit four residents were using restraints and four were using enablers which were the least restrictive and used voluntarily at their request. A similar process for the use of restraints is used for enablers. This provides for a robust process which ensures the ongoing safety and wellbeing of the resident.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, restraint records of those residents who have approved restraints and from interviews with staff.</p>
<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>	<p>FA</p>	<p>The restraint approval group, made up of the restraint coordinator, another registered nurse, the GP and the clinical manager, are responsible for the approval of the use of restraints and the restraint processes as defined in policy. The Oceania Restraint Minimisation and Safe Practice Handbook and policies. It was evident from review of restraint approval minutes, review of residents' records and interview with staff, that there are clear lines of accountability, all restraints have been approved and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/enduring power of attorney or representatives involved in the decision making, as is required by the organisation's policies and procedures, was on file in each case. Use of a restraint or an enabler is included in the care planning process and documented in the PCCPs reviewed.</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>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included in the requirements of the standard. The initial assessment is undertaken by the registered nurse with the restraint coordinator's involvement, and input from the resident's family/whānau/enduring power of attorney. The staff interviewed described the documented process. Families interviewed confirmed their involvement. The general practitioner has involvement in the final decision on the safety of the use of the restraint. The assessment process identified the underlying aetiology, history of restraint use, cultural considerations, alternatives and associated risks. A new form was introduced March 2017 for enabler assessments called the 'enabler assessment authorisation and plan'. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of residents who were using restraint.</p>
<p>Standard 2.2.3: Safe Restraint</p>	<p>FA</p>	<p>The use of restraints is actively minimised. The staff interviewed explained how the resident can be safely supported and other suitable alternatives can be introduced such as use of low beds and sensor</p>

<p>Use</p> <p>Services use restraint safely</p>		<p>mats. These options are explored before the use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records reviewed contained the necessary details, access to advocacy is provided if requested and all processes ensure respect, dignity and privacy is maintained. This is included in the PCCP under restraint/enabler use. Monitoring forms reviewed recorded that this has occurred.</p> <p>A restraint register is maintained, updated every two months and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint/enabler and sufficient information is recorded to provide an auditable record.</p> <p>All staff have undertaken training as part of the orientation/induction process. Healthcare assistants have all received training at the organisations 'grow, educate and motivate' (GEM) study days provided annually. Registered nurses received training at the study days for enrolled and registered nurses. The dates were evidenced on the training calendar and training records reviewed.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' records evidenced the individual use of restraints is reviewed and evaluated during the six monthly PCCP and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation includes all requirements of the standard, including future options to eliminate restraint use, the impact and outcomes achieved, if the policy and procedure was followed and if documentation was 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 restraint committee undertakes a six monthly review of all restraint use which includes all requirements of the standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. The clinical manager reports monthly key performance indicators to the business and care manager who reports onto the organisation's support office. Minutes of meetings include analysis and evaluation of the amount and type of restraint use in the facility, whether alternatives to restraint have been considered, the effectiveness of the restraint use, the competency of staff, the appropriateness of restraint/enabler education and feedback from the doctors, staff and families. A six-monthly internal audit is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the clinical manger, registered nurses and the clinical and quality manager, confirmed the use of restraint has been greatly reduced and maintained.</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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.