Oceania Care Company Limited - Palm Grove 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 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:	Palm Grove 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: 12 September 2017 End date: 13 September 2017

Proposed changes to current services (if any): Increasing the number of dual purpose beds from 76 and reconfiguring all 85 beds to dual purpose.

Total beds occupied across all premises included in the audit on the first day of the audit: 75

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Palm Grove Rest Home and Village can provide rest home and hospital level care for up to 85 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. The audit process included the review of policies, procedures, supporting documents, resident files, staff files and observations, and interviews with residents, family, management and staff. A review of an increase in the number of dual purpose beds from 76 and reconfiguration of all 85 beds to dual purpose was undertaken and included five studios and four apartments.

There is one improvement required relating to timeframes for completing interRAI assessments.

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.

Palm Grove Rest Home and Village staff could demonstrate an understanding of residents' rights and this knowledge is incorporated into their daily duties. Residents confirmed they are treated with respect and receive services in a manner that

considers their dignity, privacy and independence. The information relating to resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

Residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure residents and their families are informed and have choices related to the care they receive.

Links with family and the community are encouraged and maintained. The service has a documented and implemented complaints management system.

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.

The organisation's mission statement and vision is documented and displayed in the facility. The service has a current business plan and quality and risk management plan in place. The quality and risk management systems support service delivery and include internal audits, complaints management, resident and relative satisfaction surveys, and incident/accident management. Quality and risk management activities and responsibilities are shared between management, staff, residents and family. Policies have been reviewed.

The relief business and care manager is responsible for the overall management of the facility. The clinical manager and a regional and executive management team support the business and care manager in their role.

The human resource policies are implemented in relation to recruitment, selection and orientation. Staffing rosters meet requirements regarding acuity levels of residents. The information management system ensures secure and safe management of resident and staff data. 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.		Some standards applicable to this service partially attained and of low risk.

The registered nurses are responsible for the development of care plans with input from the residents, staff and family member representatives. Nursing care plan evaluations are resident-focused and indicate progress towards meeting the desired outcomes. Where the progress of a resident is different from the expected, the service responds by initiating changes to the care plan or commencing a short-term care plan for a short-term problem. There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into assessments, care planning and evaluations of care.

Planned activities are appropriate to the residents' assessed needs and abilities. Residents expressed satisfaction with the activities programme in place. Individual activities are provided either within group settings or on a one-on-one basis.

There is a medication management system in place. Medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner according to policy. The residents self-administering medicines do so according to policy.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. There is a central kitchen and on-site staff that provide the food service. The kitchen staff have completed food safety training.

Safe and appropriate environment

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

The building and plant comply with legislative requirements. The service has a current building warrant of fitness in place. The service has both a planned and reactive maintenance programme in place. The maintenance programme includes daily checks and prioritisation of tasks with monthly equipment and electrical checks.

Fixtures, fittings, and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. The service has cleaning and laundry processes in place. The service is fit for the purpose, including the external environment. Essential emergency and security systems are in place. Fire drills are completed regularly. Call bells are used to summon help for residents when needed.

The service submitted an application to HealthCERT to have five studios and four apartments approved for dual purpose use. The apartments and studios have wide entrances and there is space for aids to be used freely around resident beds. These studios and apartments are situated close to a new nurses' station and sluice.

Restraint minimisation and safe practice

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

The policies and procedures on restraint and enabler use are current and reference best practice and legislation. There is a designated restraint coordinator and a restraint committee who oversee the restraint minimisation and safe practice at the facility.

Enablers are used on a voluntary basis when a resident requests the use of an enabler. All restraint and enabler use is assessed, approved, monitored and evaluated. Staff receive education and maintain their competencies in restraint minimisation.

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 control management systems are in place to minimise the risk of infection to residents, visitors and staff. The infection control nurse is responsible for the infection prevention and control at the facility, with support from management and staff. Documentation evidenced that relevant infection control education is provided to staff at orientation and at ongoing education study days.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Infection data is collated monthly, analysed and reported at facility's meetings and to Oceania Healthcare Limited support office.

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	49	0	1	0	0	0
Criteria	0	100	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The staff at Palm Grove Rest Home and Village receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during orientation and through the ongoing annual training programme. Staff confirmed their understanding of the Code and could provide information on ways it is implemented in their everyday practice. Residents and family confirmed having choices, that their independence is encouraged and that residents can continue to practice their own personal values and beliefs. The information pack provided to residents on entry includes how to make a complaint, the code of rights pamphlet and information on the advocacy services. Education relating to the Code and complaints is provided by Health and Disability Advocacy Service.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	The information pack for new residents and their families includes information regarding informed consent. The RN or charge nurse (CN) discusses informed consent processes with residents and their families/whānau during the admission process. Staff confirmed their understanding of informed consent processes. The informed consent policy and procedure directs staff in relation to gaining informed consent.

consent.		This included guidelines for consent for resuscitation and advance directives. The GPs sign to state the competence of the resident and the resuscitation status is ticked. Staff ensure that all residents are aware of treatment and interventions planned for them. They also ensure the resident and/or significant others are included in the planning of that care. All resident files identified that required consents are collected.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through Health and Disability Commissioner is provided to residents and families. Information on advocacy services is available at the entrance to the facility. Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff. Discussions with family and residents identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files included information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	There are no set visiting hours at Palm Grove Rest Home and Village and family reported that they are encouraged to visit at any time. Residents confirmed that they are supported and encouraged to access community services with visitors or as part of the planned activities programme. The service also encourages the community to be a part of the residents' lives with visits from entertainers and community groups.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service's complaints policy and procedures are in line with the Code and includes timeframes for responding to a complaint. Complaint forms are available to all residents and visitors. The service has a complaints register in place which includes: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. The complaints policy is included in the information pack given to residents on admission. Residents and family members stated they would feel comfortable complaining. There has been one complaint to the Health and Disability Commissioner, since the previous audit, which currently remains open. The documentation relating to this complaint was reviewed and the service is currently waiting on a response from the Health and Disability Commissioner.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Information on the Code and advocacy service is available and displayed in English throughout the facility. The admission information packs reviewed included information on the Code, advocacy and complaints processes. Interviews confirmed explanations regarding their rights occurred on admission. The relief business care manager, clinical manager (CM), charge nurses (CN) and registered nurses (RNs) follow up with a discussion with residents and families during the admission process. Residents and family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to admission. The completed resident and family surveys indicated residents are aware of their rights and are satisfied with this aspect of service delivery. Residents and family interviewed received copies of the Oceania handbook. Residents interviewed confirmed they had access to an advocate if needed. The relief business and care manager advised that an advocate visits the facility on a regular basis and is also responsible for taking resident meetings.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has a philosophy that promotes dignity, respect and quality of life. The facilities' philosophy is supported with policies and procedures that are aligned with the requirements of the Privacy Act and Health and Information Privacy Code. Initial and ongoing assessments to ascertain details of people's beliefs and values are completed with the resident and family members. Interventions to support these are identified and evaluated. Residents and family confirmed that they are included in the care planning process and are addressed by their preferred name. Healthcare assistants (HCA) stated that they support the residents' independence by encouraging them to be as active as possible. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and not in public areas. There are areas in the facility which can be used for private meetings. Healthcare assistants reported they knock on bedroom doors prior to entering rooms, and signs are placed on the closed door, indicating cares are been given. This was observed on the days of the audit. Residents and families confirmed their privacy is respected. Staff have had education around abuse and neglect and could describe the reporting process should any be identified. Family, staff, residents and the general practitioners (GPs) stated that

		there is no evidence of abuse and neglect. Residents are assisted to access spiritual support when needed and there are interdenominational services at least weekly.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The Māori health plan and cultural safety procedures provide guidelines for identifying and eliminating cultural barriers. The rights of the residents/whānau to practise their own beliefs are acknowledged in the Māori health plan. The diversional therapist completes the cultural assessments on admission and updates six monthly. There are no residents who identify as Māori living at the facility. Cultural assessment are completed for Māori or residents from other cultures when applicable. Interviews with residents and family confirm their cultural needs are being met. Cultural training for staff has been provided.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Interviews confirmed that residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the residents' cultural values and beliefs. Residents' cultural values and beliefs are identified during assessment and care planning processes. The auditors verified cultural assessments are in place for residents. The service has residents from other cultures. Family and staff confirmed during interviews that the service takes additional care in making sure cultural needs of residents are identified and met. Residents confirmed in interviews their cultural needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff files have job descriptions and employment agreements with clear guidelines regarding professional boundaries. Families and residents expressed no concerns with breaches regarding professional boundaries, discrimination or harassment. Staff orientation and employee agreements include standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the healthcare assistant's role and responsibilities.
Standard 1.1.8: Good Practice	FA	The staff education programme is implemented. Staff could describe sound practice based on policies and procedures, care plans and information given to them through the RNs, charge

Consumers receive services of an appropriate standard.		nurses and GPs. Consultation is also available through the support office management team, health professionals and specialists in the region. Staff could describe how and when they have contact with specialists and consultants. Residents and families interviewed expressed satisfaction with the care delivered.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The incident/accident policy, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any incident/accident that occurs. These procedures guided staff on the process to ensure full and frank open disclosure was available. Family members confirmed they are informed if the resident has an incident/accident, or a change in health or needs. Family contact is recorded in residents' files. Interpreting services are available from the district health board. 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.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Oceania Healthcare Limited's vision, values, mission statement and philosophy are displayed in the facility. The organisation has systems in place recording the scope, direction and goals of the organisation. The business and care manager recently resigned and the service is currently being managed by a relief business and care manager. The relief business and care manager provides monthly status reports to the support office, including data on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes and clinical indicators. The relief business and care manager is supported by the clinical manager (CM), two CNs, the regional clinical quality manager and operations manager. The CM's appointment is full time and is responsible for all clinical matters. The CM has been in this position for nearly three years and has been working in aged care for many years. The facility can provide care for residents requiring rest home or hospital level of care. Occupancy during the onsite audit was 75 residents. On the first day of audit there were 40 residents requiring hospital level care, including 3 residents under the young person disability contract for under 65 year old residents and 35 rest home residents.

Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The service has appropriate systems in place to ensure the day-to-day operation should the relief business and care manager be absent. The clinical manager assumes the role and is supported by the two charge nurses and the support office. During absence of the clinical manager, the senior registered nurses and the clinical quality manager stand in.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Palm Grove Rest Home and Village uses the Oceania Healthcare Limited (Oceania) quality and risk management framework that is documented to guide practice. The service implements organisational policies and procedures to support service delivery. Policies are subject to reviews as required and all policies are current. The support office reviews all policies, with input from business and care managers. Policies are linked to the Health and Disability Service Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy or staff can access policies on the intranet service of the organisation. Staff interviewed stated new or revised policies are presented to them and they sign to confirm they have read and understood the new/revised policies. Clinical staff interviewed reported they are kept informed of quality improvements. There are monthly staff, quality improvement, RN, and infection control meetings. Health and safety, restraint and healthcare assistant meetings are held bimonthly. The senior management meetings are held at weekly intervals. There are monthly resident meetings with family able to attend if they choose to. The meetings have agendas. Service delivery is monitored through review of complaints, incidents and accidents with monthly analysis of data, surveillance of infections, and implementation of the internal audit programme. Corrective action plans are documented and evidence of resolution of issues are documented when these are identified. Corrective action timeframes completion dates and sign off were recorded. Risks are identified and there is a hazard register. The register identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Resident/family satisfaction surveys are completed six-monthly. Results from the 2016 survey indicated that residents and family are satisfied with the service.

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Adverse, unplanned or untoward events are recorded on an accident/incident form. Staff inform families after adverse events, as confirmed in clinical records and during family and resident interviews. Accident and incident forms are reviewed and signed off by the relief business and care manager. Corrective action plans are documented and address areas requiring improvement. There is an open disclosure policy. Staff confirmed that they are made aware of their responsibilities for completion of adverse events through job descriptions, and policies and procedures. Staff interviews confirmed they are made aware of their responsibilities relating to essential notification. Policy and procedures meet the terms of essential notification reporting in areas such as health and safety, human resources, and infection control. The resignation of the business and care manager has been reported to HealthCERT.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Palm Grove Rest Home and Village has written policies and procedures in relation to human resource management. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and authority. Job descriptions are reviewed on staff files along with employment agreements, reference checking, criminal vetting, drug testing, completed orientations and competency assessments. The service keeps current copies of annual practising certificates for all staff and contracted health professionals that require these to practise. The CM is responsible for the in-service education programme. Competency assessment questionnaires are available and completed competencies were reviewed. Staff are supported to complete education via external education providers. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed. The service has an orientation/induction programme and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete. Staff performance is reviewed at the end of this period. Orientation and induction includes the essential components of services provided. Care staff interviewed confirmed they have completed an orientation, including competency assessments. The service has six RNs who have completed InterRAI training.
Standard 1.2.8: Service Provider	FA	There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. The service uses fortnightly roll-over rosters to ensure

Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		appropriate staffing. There is RN cover 24 hours a day, with 2 RNs on during the day and 1 RN on duty during the night. Nominated registered nurses, the clinical manager and the relief business and care manager are on call after hours. Care staff interviewed reported adequate staff is available and that they are able to get through their work. Residents in the studios and apartments reconfigured as dual purpose are receiving assistance during cares. The relief business and care manager confirmed that staffing is adjusted to suit the care needs of these residents should they change. Residents and family interviewed report staff provide them with adequate care.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents' information is stored securely at nurses' stations, including clinical notes which are current and accessible to clinical staff. Information containing sensitive resident information is not displayed and could not be viewed by other resident's medical care or members of the public. Entries are legible, dated and signed by the relevant healthcare assistant, RN or other staff member, including designation. Approved abbreviations are listed. The service retains relevant and appropriate information to identify and track residents' records. There is sufficient detail in residents' files to identify each resident's ongoing care, history and activities. Documentation in individual resident files demonstrated service integration. The resident's national health index (NHI) number, name, date of birth and GP are used as the unique identifier. Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The information pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the family/whānau of choice and, where appropriate, local communities and referral agencies. Data sampled confirmed that admission requirements are conducted within the required timeframes. The admission agreement outlines services provided as part of the agreement to entry. Residents and relatives interviewed confirmed that they received sufficient information regarding the services to be provided.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a documented process for the management of transfers and discharges. Residents' information is communicated to the service they are referred to. Residents and their families are involved in all exit or discharges to and from the service. Evidence in the resident's records confirms this.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. The medication entries sampled on the electronic system complied with legislation, protocols and guidelines. Medications are stored securely. There was evidence of medication reconciliation in the residents' files reviewed. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated and photos uploaded for easy identification. An annual medication competency is completed for all staff administering medications and medication training records were sighted. Staff were observed administering medication according to policy. Weekly and six-monthly stocktakes are conducted and all medications are stored appropriately. The residents who are self-administering medication do so according to policy.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is prepared at the facility. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the chef confirmed awareness on dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. The residents' weights are monitored regularly. Supplements are provided to residents with identified weight loss issues. The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers. Records of temperature monitoring on fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The residents and family interviewed indicated satisfaction with the food service.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is	FA	When a resident is declined entry, this is recorded on the pre-enquiry form and the information of the reason for this are made known to all concerned. Other options or alternative services available are presented and the referral agency is informed to ensure that the resident would is admitted to the appropriate service provider. Declined entry occurs if the facility has no beds

declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		available or if the resident's level of care is not appropriate for the service.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial risk assessments (excluding interRAI) are completed within the required timeframe on admission (refer to 1.3.3.3). The nursing staff utilise standardised risk assessment tools on admission. The assessments and care plans are detailed and include input from the resident, family and other health team members as appropriate. In interviews, residents and relatives expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans are resident focused, integrated and provide continuity of service delivery. The assessed information is used to generate long-term care plans and short-term care plans for acute needs (refer to 1.3.3.3). The care goals are specific and measurable. The care plan interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The documented interventions in short-term care plans and long-term care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP interviews. The progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies were observed and the staff confirmed they have access to the supplies and products they needed.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Residents interviewed confirmed that the planned activities are meaningful. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. Interview with the diversional therapist (DT) confirmed they modify activities based on the residents' responses and interests and also according to the capability and cognitive abilities of the residents. The residents were observed to be participating in activities on the audit days. Residents were observed to be going offsite with family/friends and in planned community activities. There are

		planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. The activities assessments are completed on admission and the activities care plans are formulated following the assessments. The activities care plans are reviewed when the long-term care plans are evaluated. The DT maintains records of the residents' participation in the activities programme. There was evidence of allied health staff involvement in the assessments and treatment of residents, such as physiotherapy.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The residents' long-term care plans, interRAI assessments and activity plans are evaluated at least six-monthly and updated when there are any changes. Resident, relative and staff input is sought in all aspects of care. Evaluations record how the resident is progressing towards meeting their goals and responses to interventions. The short-term care plans are developed when needed and signed and closed out when the short-term problem has resolved. GP medical evaluations are conducted three-monthly or when condition of a resident requires medical reassessment.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	There is a documented process for the management of all referrals. The GPs confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GPs.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during	FA	Documented processes for the management of waste and hazardous substances are in place. The hazard register is current. Policies and procedures for chemicals specify labelling requirements in line with legislation, including the requirement for labels to be clear, legible and free from damage. Material safety data sheets are available throughout the facility and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous

service delivery.		substances. Interviews with the household staff confirmed this. There is provision and availability of personal protective clothing and equipment including: goggles/visors; gloves; aprons; footwear; and masks. During a tour of the facility, personal protective clothing and equipment was observed in areas where there were risks.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed. The service has a planned maintenance schedule implemented with a test and tag programme. Checking and calibration of clinical equipment is completed annually. There have been no building modifications since the last audit. Interviews with staff and observation of the facility confirmed there is adequate equipment including, for example, pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There are quiet areas throughout the facility for residents and visitors to meet providing privacy when required. There is an outside area with shade and outdoor furniture. There are ramps and rails at entrance doors to support residents with disabilities. The corridors are wide to promote safe mobility, use of aids and independence. The service submitted an application to have five studios and four apartments approved for dual purpose use. Doors to the apartments and studios are wide and allow for aids to be moved freely in and around the resident's room. The studios all have en-suites. The apartments are larger with separate bedrooms and a full en-suite. All studios and apartments have working call bells. These studios and apartments are situated close to a new nurses' station and sluice. These rooms are suitable for dual purpose use.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible toilets/bathing facilities. Visitors' toilets and residents' toilets are located close to communal areas. All the toilets have a system that indicates if it is engaged or vacant. All the residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence. Residents and family members reported that there are sufficient toilets and showers. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.

Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space in all the bedrooms to allow residents and staff to safely move around in the room. Equipment was sighted in hospital rooms where required. There was sufficient space for at least two staff, the resident and the equipment, for example, hoists and wheelchairs. The residents' rooms are personalised with furnishings, photos and other personal possessions. Residents and families are encouraged to personalise their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The service has lounges and dining areas including areas that can be used for activities. All communal areas are easily accessed by residents and staff. Residents are able to access areas for privacy, when required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely. There is furniture in the garden areas and designated parking spaces for mobility scooters.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Personal laundry services are completed on site. Linen and other laundry is sent to another Oceania facility for laundry services. The linen trolleys are used for residents' individual laundry. Staff interviewed confirmed knowledge of their roles including management of any infectious linen. There are cleaners on site during the day, seven days a week. Cleaners have a lockable cupboard to store chemicals. The cleaners are aware that the trolley must be with them at all times. Cleaners were observed on the days of the audit keeping the cleaning trolley in sight. Chemicals are in appropriately labelled containers. Laundry chemicals are administered through a closed system which is managed by a chemical contractor company. Products are used with training around use of products provided.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	An evacuation plan has been approved by the New Zealand Fire Service. The service has an evacuation policy on emergency and security situations is in place. Fire drills are completed six-monthly. The orientation programme includes fire and security training. Checking the fire exits for clearance is on the maintenance daily schedule. Staff confirmed their awareness of emergency procedures. Fire equipment was sighted on the day of audit and all equipment had

		been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including: food; water; blankets; emergency lighting; and gas barbeques. An escalating electronic call bell system is utilised. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways and dining rooms. Call bell audits are routinely completed. Residents and family stated there are prompt responses to call bells. External doors leading to the gardens are locked after sunset. These doors can only be opened from the inside. Afternoon staff complete a security check of all external doors in the evening to confirm security measures are in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The service has procedures in place to ensure they are responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Monthly room temperature checks are monitored. There is a designated external smoking area for residents, however, there are currently no smokers at the facility. Family and residents stated that the building is maintained at an appropriate temperature in both winter and summer.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Palm Grove Rest Home and Village provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. The CM is the infection control nurse (ICN) and has access to external specialist advice from GPs, district health board infection control specialists and microbiologists, when required. A documented role description for the ICN, including role and responsibilities is in place. The infection control programme is appropriate for the size and complexity of the service. It is reviewed annually. Staff are made aware of new infections through daily handovers on each shift, progress notes and short term care plans. There are processes in place to isolate infectious residents when required. Hand sanitizers and gels are available for staff, residents and visitors to use. Staff interviewed demonstrated an understanding of the infection prevention and control programme.
Standard 3.2: Implementing the infection	FA	The ICN is responsible for implementing the infection control programme. The ICN indicated there are adequate human, physical, and information resources to implement the programme.

control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		Infection control reports are discussed at the facility's meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.
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 organisation has documented policies and procedures in place that reflect current best practice relating to infection prevention and control. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and are able to locate policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education on infection prevention and control is provided by ICN and external infection control specialists. It is a mandatory requirement for all staff. A record of attendance is maintained and was evidenced. External contact resources include: GP; laboratories; and local district health board staff. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, analysed, monitored and reviewed monthly. Any significant trends or common possible causative factors are identified and action plans are instigated. Staff interviewed reported they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required timeframe when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, confirmed at GP interviews. The Oceania support office conducts benchmarking in infection prevention and control with other Oceania facilities and this is shared with management and staff. The ICN confirmed an outbreak occurred in 2016 and there is evidence this was reported to the required authority and managed according to policy and outbreak guidelines.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The definitions of restraint and enabler are congruent with the definition in the standard. The process of assessment, consent, care planning, monitoring and evaluation of restraint and enabler use is recorded and implemented. There were seven residents at the facility requesting the use of enablers and four residents assessed as requiring restraint on the days of the audit. The restraint and enabler use are documented in residents' care plans and clinical files reviewed. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. This was confirmed in staff, resident, and management interviews. In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice, enabler usage and prevention and/or de-escalation education and training is provided. Staff restraint competencies are current.
Standard 2.2.1: Restraint approval and processes 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.	FA	The Oceania clinical and quality team are responsible for approving any form or type of restraint practice used at Oceania facilities nationally. Oversight of restraint use at each individual Oceania facility is the responsibility of the restraint coordinator. The restraint coordinator at Palm Grove Rest Home and Village is one of the charge nurses (RN). The responsibilities for this role are defined in the position description. The restraint coordinator has completed training in restraint minimisation and restraint management relevant to their role, and this was sighted. Restraints are authorised following a comprehensive assessment of the resident. The approval includes consultation with other members of the multidisciplinary team. The restraint consent forms evidence consent for restraint is obtained from the GP, restraint coordinator and the resident and/or a family member.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessment is completed prior to commencement of any restraint. The clinical files of residents using restraint evidenced the restraint assessment authorisation and plans were in place. Restraint assessments evidence the restraint coordinator's sign off and that evidence all appropriate factors have been taken into consideration.
Standard 2.2.3: Safe Restraint Use	FA	The Oceania policies and procedures on the safe use of restraint detail the processes of

Services use restraint safely		assessment, approval, consent, documentation, evaluation, and their required implementation. The policies guide staff in the safe use of restraint. Strategies are implemented prior to the use of restraint to prevent the resident from incurring injury for example: the use of low beds; mattresses and sensor mats. There have been no adverse outcomes or sentinel events relating to restraint use reported to the Oceania support office. Staff training and education in restraint use includes appropriate orientation and ongoing education. Evidence of ongoing education regarding restraint and challenging behaviours is evident. Restraint competency testing of staff is included in the education of staff. Restraint is included in the mandatory study days for all staff, as well as RN study days. The healthcare assistants are responsible for monitoring and completing restraint forms when the restraint is in use. The restraint register is up to date. It records all necessary information to provide an auditable trail of restraint events.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Evaluation of restraint use occurs through restraint event reporting by the facility to the Oceania support office as a clinical key performance indicator. Each individual episode of restraint is evaluated. The clinical files of residents using restraint evidenced the restraint evaluation forms are completed. These forms include all the relevant factors in this standard. The restraint minimisation team meeting minutes evidence evaluation of each restraint use at the facility.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	There is evidence of monitoring and quality review of the use of restraints at the facility. The restraint minimisation team meeting minutes evidence review of the compliance with the standard. The meeting minutes include: individual resident's restraint review; restraint register update; education review; and any relevant restraint issues. Audits are conducted of restraint use and include review of the clinical files of residents who use restraints. Oceania national restraint authority group terms of reference are recorded. This group meet annually to review the compliance with the restraint standard and review of restraint use nationally. The last Oceania national restraint authority group meeting was conducted in March 2017.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	The review of residents’ clinical files evidenced all interRAI reassessments were completed within the six-month timeframe. The initial interRAI assessments were not always completed within the 21 days of residents’ admissions. This was evidenced in three of the nine clinical files reviewed. Interview with the CM confirmed all interRAI reassessments are up to date, however, the initial interRAI assessments have not consistently been completed within the required timeframe.	Not all initial interRAI assessments are completed within the required 21 days of a resident’s admission to the facility.	Provide evidence the initial interRAI assessments are completed within the required 21 days of a resident’s admission to the facility. 60 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.