Oceania Care Company Limited - Woburn Rest Home

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:	Woburn Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 20 August 2019 End date: 21 August 2019

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: 32

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

Woburn Rest Home is part of Oceania Healthcare Limited. The facility is certified to provide services for 33 residents requiring rest home or dementia level of care. There were 32 residents at the facility on the first day of the audit.

This certification audit was conducted against the Health and Disability Service Standards and the facility's contract with the district health board.

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

There were no areas identified as requiring improvement at this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Information regarding the Health and Disability Commissioners' Code of Health and Disability Consumers' Rights; the complaints process; and the Health and Disability Advocacy Service is made available to residents and their families on admission and is accessible to residents and their families in the facility.

Staff interviews demonstrated an understanding of residents' rights and obligations. Residents and family members confirmed their rights are being met.

Residents' cultural and spiritual beliefs are identified on admission and there is access to cultural and spiritual support if required. Informed consent is practised and written consent is obtained when required.

Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents. Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

Staff communicate with residents and family members following incidents and this is recorded in the resident's file. Interviews with residents, family and the general practitioner confirmed that the environment is conducive to communication, that issues are identified where applicable, and that staff are respectful of residents' needs.

There is a documented complaints management system that aligns with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Complaints are investigated and documented, with corrective actions implemented where required. A complaints register is maintained. There have been no complaints to external agencies since the last audit.

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.

Oceania Healthcare Limited is the governing body responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned.

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement meetings. Meetings are held that include reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

The facility has an incident and accident management system to record and report adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting.

The business and care manager is a registered nurse and responsible for the overall management of the facility and is supported by the regional clinical quality manager. The business and care manager, supported by registered nurses, is responsible for clinical management and oversight of services.

Human resource policies and procedures guide practice and there is evidence that human resource processes are being followed. There is a role specific orientation programme and ongoing training is provided. There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. Staffing levels are adequate across the services.

Systems are in place to ensure the consumer information management system is protected from unauthorised access.

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.

Residents receive services from suitably experienced and qualified staff. Initial assessments, interRAI assessments and person-centred care plans are completed and evaluated by registered nurses. The general practitioner reviews residents monthly or sooner

if there is a change, and three-monthly if stable. Short-term care plans are in place for all acute problems. Residents and families interviewed confirmed they are involved in the care planning and the review process.

There is a group activity programme developed and implemented in the service. Participation is encouraged and is voluntary. Individual activities are provided either within group settings or on a one-on-one basis. The residents in the dementia unit have 24-hour activity plans completed. Community links are maintained, and community outings are arranged. The residents and families interviewed confirmed satisfaction with the activities programme.

Medication policies reflect legislative requirements and guidelines. Medicines are stored and managed appropriately in line with legislation and guidelines. Registered nurses and senior health care assistants are responsible for administration of medicines and complete annual education and medication competencies. The medicines policy includes a section on the self-administration of medicines. At the time of the audit there were two residents self-administering medicines.

At Woburn Rest Home all meals are prepared on-site in a large commercial kitchen. There is a current food control plan. The chef provides oversight of food service provision. All kitchen staff had completed relevant food safety training. The menu had been reviewed by a dietitian at organisational level and is suitable for older people. Resident's individual food preferences, dislikes and dietary requirements are catered for. Residents interviewed report satisfaction with the food service.

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.

There is a current building warrant of fitness and an approved fire evacuation plan. Essential security systems are in place to ensure resident safety. Six monthly trial evacuations are undertaken.

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

Residents' rooms provide single accommodation and are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has a monitored call bell system for residents to summon help, when needed, in a timely manner.

There are documented and implemented policies and procedures for cleaning and waste management. Cleaning and laundry services, provided seven days a week by household staff, are monitored.

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.

Restraint minimisation policy and procedures and the definitions of restraint and enablers are congruent with the restraint minimisation and safe practice standard. Interviews with staff confirm their understanding that enabler use is voluntarily and used when a resident requests an enabler to assist them to maintain independence and/or safety.

Staff complete education for challenging behaviour. There were no residents with restraint or enablers in use at time of audit.

Infection prevention and control

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

The service provides an environment which minimises the risk of infections to residents, staff and visitors. Specialist infection prevention and control advice can be accessed from the district health board; microbiologist, general practitioners and infection control specialists if needed.

Staff are guided by policies and procedures and demonstrated good principles and safe practice around infection control on the days of audit. Employees are provided with training on infection control practices at induction and they complete ongoing education at annual study days and as required.

Infection surveillance is undertaken, data is analysed, trended, benchmarked and results are reported through all levels of the organisation.

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	45	0	0	0	0	0
Criteria	0	93	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The organisation has implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). All staff have received education on the Code as part of orientation and the mandatory annual education programme. Staff interviews confirmed their understanding of the Code and described practices that evidence an understanding of their obligations. Evidence that the Code is implemented in their everyday practice includes, but is not limited to: maintaining residents' privacy; providing residents with choices (e.g., options for rising in the morning; shower times; food; clothing and activities); involving family and residents in decision making; and ensuring residents are able to practise their own personal values and beliefs. Resident and family interviews, as well as observation confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff are respectful towards residents and their families and resident interviews confirmed they receive information relevant to their needs.
Standard 1.1.10: Informed Consent Consumers and where	FA	The organisation's informed consent policy provides guidelines for staff. The policy ensures that staff members adhere to the legal and ethical requirements of informed consent and informed choice for health care services and service provision. It includes guidelines for consent for: treatment; photographs; specific

appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.		cares; collection and storage of information; and advance directives. The policy ensures that all residents or their family/EPOA are informed about the management and care to be provided in order that they may arrive at a reasoned and non-pressured decision about any proposed treatment or procedure. It describes what consent involves and how it may be facilitated, obtained, refused and withdrawn. Cultural considerations are identified such as the involvement of the wider whānau and allowing time for decision making. The information pack provided on admission includes information regarding informed consent. The BCM or RN discuss informed consent with family and the resident during the admission process to ensure understanding. Staff receive orientation and training on informed consent and staff interviews confirmed they are aware of the informed consent process. There is an advance directives and an end of life decision policy to ensure that appropriate ethical concepts are upheld in resident treatment and care situations in relation to end of life. The policy defines the procedure for obtaining an advance directive and who may or may not make an advance directive. File reviews demonstrated that advance directives and resuscitation orders were completed in accordance with policy.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There is an advocacy policy and procedure for staff to follow to ensure that residents and their families have a right to be represented and express views or concerns about their situation. It includes making them aware of the availability of advocacy services and supports access to advocacy services. Information regarding the availability of the Nationwide Health and Disability Advocacy Service is included in the information packs provided to residents and family on admission to the facility. Additional advocacy services brochures are also available at the entrance to the facility. The complaints policy also includes making residents aware of their right to advocacy when making a complaint. Interview with the BCM confirmed that advocacy services can be accessed through the local Aged Concern and services within the DHB such as, older person mental health service, if required. Interviews with residents and family confirmed that they are aware of the right to advocacy and that advocacy services are available.
Standard 1.1.12: Links With Family/Whānau And Other	FA	Observations and resident, family and staff interviews confirmed that residents may have access to visitors of their choice. There are areas where a resident and family can meet in private. Interviews with residents and family and observation, confirmed that families are welcome in the facility and were free to visit at any

Community Resources Consumers are able to maintain links with their family/whānau and their community.		time. Interview with residents, families and staff confirmed that residents are free to leave the facility and do so to be involved in family events, visit local clubs and go shopping. A local companion driving service is utilised by many residents to make outings into the community. The activities programme, and the content of care plans include twice weekly outings in the community to places of interest such as local gardens.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisation's complaints policy outlines the complaints procedure that is in line with the Code and includes the expected timeframes for responding to a complaint. The complaint process is made available as part of the admission pack and explained by the BCM or RN on the resident's admission. The complaint forms are also available at the entrance to the facility. The BCM is responsible for managing complaints. There had been three complaints since the previous audit. An up-to-date complaints register is in place that includes the date the complaint is received; the source of the complaint; a description of the complaint; resolution and the date the complaint is signed off. Evidence relating to each lodged complaint is held in the complaints folder and register. Interview with the BCM and a review of complaints indicated that complaints are investigated promptly, and issues are resolved in a timely manner. Interviews with the BCM, staff and residents confirmed that residents are encouraged to raise any concerns and provide feedback on services and this includes discussing and explaining the complaints process through resident meetings. Resident and family interviews confirmed that they are aware of the complaints process. Residents and family stated that they could raise any issues directly with the BCM and that these are dealt with effectively and efficiently. There have been no complaints to external agencies since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	New residents and their families are provided with information about the Code as part of an information pack provided on admission to the facility. The pack includes information on the complaints process and the advocacy service. The business and care manager (BCM) or the registered nurse (RN) explains the Code during the admission process to ensure understanding. The Code and associated information are also available in information brochures which are displayed throughout the facility and available to take away and read in private. Information on the Code is also displayed in posters in English and te reo Māori at the entrance to the facility and within resident areas in the facility.

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 organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code to ensure that a resident's right to privacy and dignity is upheld. Resident, family and staff interviews and observation confirmed that: staff knock on bedroom and bathroom doors prior to entering rooms; ensured that doors were shut when personal cares were being provided and residents were suitably attired when taken to the bathrooms. Interviews and observation confirmed that conversations of a personal nature were held in private and confidentiality was maintained. Residents and family members' interviews confirmed that resident privacy is respected. The organisation has a policy on sexuality and intimacy that acknowledges residents' rights to privacy and intimacy as identified by each resident. It includes identifying resident needs and responding to expressions of sexuality. Staff interviews confirmed that they assist residents to choose their own clothing to wear each day. Resident interviews and observation confirmed that residents could wear clothing, adornments and makeup of their choice each day. Residents' files reviewed, staff, and family interviews and satisfaction surveys confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented and upheld. There is an abuse and neglect policy that sets out the guidelines to prevent, identify, report and correct incidences of abuse and neglect. It includes managing the risk to residents and staff arising from abuse or neglect. Staff receive orientation and mandatory annual training on abuse and neglect. Staff interviews identified that staff are aware of their obligations to report any incidences of suspected abuse. Staff and family interviews confirmed that there was no evidence of abuse or neglect. There were no documented incidents of abuse or neglect.
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 organisation has a Māori health plan/policy that demonstrates Oceania Healthcare Limited's (Oceania) commitment to ensuring residents who identify as Māori have their needs met in a manner that respects and acknowledges their individual and cultural values and beliefs. There is also a culturally competent services policy that describes for staff how culturally competent services should be delivered. Interview with the BCM confirmed that support for staff for providing culturally appropriate care, and for Māori residents and their families, would be sourced if required through a local kaumātua or local medical centre. Staff receive training in cultural safety and values at orientation and as well as part of the mandatory annual education programme. There were two residents who identified as Māori at the time of audit. Staff interviews confirmed awareness of the importance of involving whānau in the delivery of care.

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	Staff and family interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family are involved in assessment and care planning processes. The information pack advises residents and family/enduring power of attorney (EPOA) to discuss cultural, ethnic and spiritual needs so that the facility can provide care that meets the resident's needs. Information gathered during assessments includes identifying a resident's specific cultural needs, spiritual values, and beliefs. Assessments also include obtaining background information on a resident's spiritual and cultural preferences, which includes, but is not limited to: beliefs; cultural identity; and spirituality. This information informs activities that are tailored to meet identified needs and preferences. The spirituality and counselling policy ensures access for residents to a chosen spiritual advisor or counsellor where requested. For those residents who chose to attend, the Anglican Church provides an interdenominational church service once a week, and a Catholic priest also provides a weekly mass and communion. Both churches are available to provide room and facility blessings when requested.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	There is policy to ensure that the environment for residents is free from discrimination; coercion; harassment; and financial exploitation. The policy describes for staff how this will be prevented and, where suspected, reported. Job descriptions include the responsibilities of the position, including ethical issues relevant to each role. Staff interviews confirmed awareness of their obligation to report any evidence of discrimination, abuse and neglect, harassment and exploitation. There were no documented complaints or incidents recorded since the previous audit relating to any form of discrimination, coercion or harassment. Staff are required to sign and abide by the Oceania code of conduct. Staff mandatory training includes professional boundaries. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Interviews with residents and families confirmed that staff maintain appropriate professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The facility implements the Oceania policies and procedures which are current and based on good practice and current legislation and guidelines. The policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice. There are relevant training programmes for all staff. The facility data is entered onto the Oceania electronic database and benchmarking occurs across all

		Oceania facilities. The regional clinical and quality manager reviews all data regularly. There is at least weekly contact between the BCM and the regional clinical quality manager and where required performance measures and data are discussed. Staff interviews and monthly meeting minutes identified that the results of benchmarking are made available to, and discussed with, staff. Staff, resident and family interviews, residents' file notes and observation of service delivery confirmed that resident care was based on good practice guidelines.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy that sets out the process to guide staff to ensure there is open disclosure of any adverse event where a resident has experienced any unintended harm while receiving care. Completed incident forms, residents' records and resident and family interviews demonstrated that family are informed if the resident has an incident/accident; a change in health or a change in needs. Family contact is recorded on incident forms and in residents' files. Staff, resident and family interviews confirmed that family are included in resident care planning meetings. Two monthly resident meetings inform residents and families of facility activities. All family are welcome to attend meetings. Meetings are advertised on the facility notice board, on the weekly events planner, in the two-monthly facility newsletter and through personal reminders by the activities coordinator. Interviews with the activities coordinator advised that family are also emailed to invite them to the meeting. Meeting minutes demonstrate good attendance by residents and families. Meetings also provide an opportunity to provide feedback and make suggestions for improvement as well as raise and discuss issues/concerns with management. Minutes of the family meetings sighted provided evidence that a wide range of subjects are discussed such as, but not limited to: resident and staff movements; compliments and complaints; facility changes; activities; and resident relevant policy changes. Copies of the meeting minutes are provided to residents in person shortly after the meeting and residents can comment on the documented minutes prior to finalisation. Copies of the activities plan and menu are also available to residents and families. Resident and family interviews confirmed that the BCM and staff were approachable and available to discuss queries and issues. Interviews with residents and family identified the BCM addressed concerns and queries promptly and proactively. There is a policy that provides guidance and procedures for staff to ensure that residents who do not use English as their first language are offered interpreting services. It states that staff have access to a list of interpreting services and family may only interpret with a resident's consent. Interview with the BCM confirmed that a list of interpreter services is available to the facility through the district health board (DHB) or local medical centre if required. Staff represent a number of ethnicities and can communicate with residents in their native tongue if the resident wishes, such as: South African; Fijian; Indian; Welsh; and Māori. At the time of the audit there were no residents who required an interpreter.

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 facility is part of the Oceania Group with the executive management team providing support to the facility. Communication between the facility and Oceania executive management occurs monthly with the regional clinical and quality manager providing support during the audit. The monthly management report provides the executive management with progress against identified indicators. Oceania has a documented mission statement, vision and values. These are displayed at the entrance to the facility. There is an overarching Oceania business plan. In addition, there is a 2019 - 2020 business plan specific to Woburn Rest Home that sets out the direction of the facility. The facility is managed by a BCM who has been in this role for over two years. The BCM is a RN and has five years previous experience as a charge nurse (CN) and acting clinical manager in aged related residential care (ARRC). The BCM has completed Oceania leadership training. The clinical care at the facility is overseen by the BCM, with the assistance of an interim RN. The interim RN has over 15 years' experience as clinical manager in other ARRC facilities and 40 years' experience as a RN. The interim RN role concluded on the second day of the audit. A permanent RN has recently been appointed to the role of CN and along with the other RNs will support the BCM with the oversight of clinical care. The CN is a RN, with seven years overseas experience in medical and surgical nursing as a CN and has experience as an infection control specialist. The CN completed the New Zealand competency assessment programme with practical experience in ARRC and dementia. The CN has completed and orientation with the interim RN. The senior team is supported in their roles by the Oceania executive and regional teams. The facility is certified to provide rest home care for up to 22 residents and dementia level care for up to 11 residents. There were 32 beds occupied at the time of the audit, this included: 11 residents who had been assessed as requiring dementia level care and 21 residents assessed as requiring rest home level care. The facility has contracts with the district health board (DHB) for the provision of rest home and dementia level care; mental health, respite care and day care. Included in the total occupancy numbers was one resident receiving respite care assessed as requiring dementia level of care.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the	FA	During a temporary absence of the BCM, the CN, with support from BCM from another Oceania facility in the region and/or the regional operations manager, would be responsible for the day to day operation of the service. In the absence of the CN or the other RN, and the regional clinical and quality manager will support the

service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		BCM to ensure continuity of clinical services. The RN position would be backfilled by a temporary RN.
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	The facility utilises Oceania's documented quality and risk management framework that is available to staff to guide service delivery. All policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies are presented to staff at staff meetings and made available in the staff room. Staff confirmed that they are advised of new and updated policies and sign to confirm that they have read the new or revised policies. The service delivery is monitored through the organisation's reporting systems utilising several clinical indicators such as: health and safety; incidents and events; near misses; infections; falls; skin tears; and medication errors. There was evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data sighted provided evidenced that data is being collected and collated with the identification of trends and analysis of data. Corrective action plans are developed, implemented, evaluated and signed off where required. There is communication with staff of any subsequent changes to procedures and practice through monthly meetings. The combined staff, quality and infection control meetings and the health and safety meetings evidenced all aspects of: quality improvement; risk management; and clinical indicators are discussed. Staff reported that they are kept informed of quality improvements. Copies of meeting minutes are available for review in the staff room for staff that were unable to attend a meeting. Residents and families are notified of relevant updates such as signing in and out of the facility requirements, through the facility's resident meetings. Satisfaction surveys for residents and family are completed as part of the internal audit programme. Corrective actions are developed and implemented for issues identified from surveys and these are presented and discussed at resident meetings. The March 2019 surveys reviewed evidenced satisfaction with services provided and this was confirmed by family interviews. The organisation has a risk management programme in place that records the management of risks in clinical, environment, human resource and other areas specific to the facility. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and

		safety processes and of the need to report hazards, accidents and incidents promptly. Health and safety events such as: hazards; upcoming maintenance or renovations; and safe lifting are discussed at health and safety meetings. Learnings are shared with staff at staff meetings. There is a nominated and elected health and safety representative who has been in the role for two years and has completed an orientation into the role. Interviews confirmed a clear understanding of the obligations of the role and health and safety, including role in staff orientation to health and safety. Hazard reporting forms and staff interviews confirmed that hazard reporting is actively encouraged. There was evidence that identified hazards are addressed promptly and risks minimised. A current hazard register is available, and this is reviewed annually. Interview advised that new hazards were addressed promptly. However, in the advent that a newly identified hazard could not be resolved immediately, it would be updated on the hazard register.
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	Policy and procedures reference essential notification reporting for example: health and safety; human resources and infection control. The BCM is aware of situations which require the facility to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles. Interviews confirmed that these would be reported to the appropriate authority by the Oceania support office. There have been no events since the last audit requiring essential notification. Interviews with staff and review of adverse event forms confirmed that all staff are encouraged to recognise and report adverse events. Staff interviews confirmed an understanding of the adverse event reporting process and their obligation to document all untoward events. A review of staff records demonstrated that staff receive education at orientation on the incident/accident reporting process and this is reiterated at staff meetings. There is an implemented incident/accident reporting process and incident/accident reporting forms are available on the health and safety notice board in the staff room. Interviews with staff and review of documentation evidenced that staff document adverse, unplanned or untoward events on an incident/accident form which is signed off by the BCM. Incident/accident reports selected for review evidenced that an assessment had been conducted and observations completed. There is evidence of a corresponding note in the resident's progress notes and notification of the resident's nominated next of kin where appropriate. Corrective actions arising from incidents/accidents were implemented for resident and staff incidents/accidents. Information gathered is shared at monthly meetings with incidents/accidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Specific learnings and results from incidents/accidents inform quality improvement processes and are regularly shared at the

		combined staff, quality and infection control and health and safety and staff meetings.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; a signed employment agreement; position specific job description; and police vetting. An appraisal schedule is in place and all staff files reviewed evidenced a current performance appraisal. The facility has recently implemented the Oceania electronic learning management system to record and track: staff training; competencies and performance appraisals. This includes systems to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that require them including: RNs; general practitioners (GPs); physiotherapist; podiatrist; pharmacists; and dietitian. An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks, including personal cares. Staff working in the dementia unit receive orientation specific to the requirements of working in the dementia unit. Interviews confirmed that new staff are supported and buddied over their orientation into their new roles. The organisation has implemented the Oceania documented role specific mandatory annual education and training modules. Education session attendance records evidenced that ongoing education is provided. Training records and interviews confirmed that staff have undertaken a minimum of eight hours of relevant training. In addition, of four of eight health care assistants (HCAs)have completed the Career force dementia specific training and the other four are in the process of training. Three of four RNs have completed interRAI assessments training and competencies. This number also includes the interim RN whose last day was day two of the audit, the CN and the BCM. A review of the management system confirmed that processes are in place to ensure that all staff complete their required training and competencies. Annual competencies are completed by care staff include, for example: fire training; handwashing; infection control; restraint comprehension; and medication management.
Standard 1.2.8: Service Provider Availability Consumers receive timely,	FA	There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. There are set rosters with most staff working set shifts with a repeating cycle of three days on and three

appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		days off. Rosters are confirmed and made available to staff one month in advance. Staffing levels are reviewed to accommodate anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes residents' needs. There are sufficient RNs and HCAs available to safely maintain the rosters for the provision of care to accommodate increases in workloads and acuity of residents. The facility includes a 22 bed 'U' shaped rest home wing and a secure dementia wing, each with a nurses' station. The BCM's office is in the dementia wing. In addition to the BCM, who is on duty on the morning shifts from Monday to Friday, there is an RN on duty on the morning shift on Tuesday, Wednesday and Thursday. With the recruitment of the new CN, these RN shifts will increase to include Saturday morning shifts. In the dementia unit there are two HCAs on each morning and afternoon shift and one on each night shift seven days per week. In the rest home wing there are two HCAs on each morning and afternoon shift and one on each night shift, seven days per week. In addition, there was always one laundry assistant on duty at night. Interview with a HCA who also worked in the laundry on night shift, confirmed that the laundry assistant was available to assist when needed. The BCM interviewed stated typically, where assistance in the dementia unit was required, the HCA in the rest home would assist and would be relieved in the rest home by the laundry assistant. Laundry assistants complete the HCA training. Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract. In each wing there is at least one staff member who has current medication competencies and at least two who have a current first aid certificate on each shift. There are 35 staff, including: the management team; administration; clinical staff; activities assistant; and household staff. Household staff include cleaners, laundry assistants and kitchen staff who provide services seven day a week. The BCM, the CN or an RN are on call after hours to the rest home and dementia unit. Observation of service delivery confirmed that residents' needs were being met in a timely manner. Family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed that they are at times busy but can complete their scheduled tasks and resident cares over their shift.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents' records are maintained in hardcopy with electronic medication charts in use. Residents' information, including progress notes, are legible and entered into the resident's record in an accurate and timely manner, identifying the name and designation of the person making the entry. Residents' progress notes are completed every shift, detailing resident response to service provision. There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of their obligations and the procedures for maintaining confidentiality of resident information. Resident care and support information can be accessed in a timely manner and is protected from unauthorised access by being locked away when not in use. Archived

		records are securely stored for one year on-site and then off-site. Archived records can be retrieved on the same day if required. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the resident's family and resident where applicable. The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel only.
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	Residents are assessed as requiring rest home level of care or specialist dementia services prior to entry. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the BCM. The residents/family/representative are provided with an information pack. There is information about the service and the admission process as well as the service philosophy and practices specific to the dementia unit which is provided to the family members of residents with dementia. The admission agreement defines the scope of the service, includes all contractual requirements and evidenced resident and/or family sign off. Signed and dated resident admission agreements are completed within the required timeframe. Residents' records reviewed confirmed entry to service information and processes comply with entry criteria. Residents and family members interviewed stated they were satisfied with the admission process and the information provided on entry to service.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The services use the DHBs 'yellow envelope' system to facilitate a transfer to the DHB and 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 RNs. Staff demonstrated open communication between all services, the resident and the family.
Standard 1.3.12: Medicine Management	FA	There are policies and procedures that describe medication management that align with current legislation and accepted medicines guidelines for aged residential care. Medication areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		dispensed packs. The fridge where medications are kept has required temperature checks completed. All staff (RNs or senior HCAs assistants) who administer medicines have completed medication competencies. Staff attend annual medication education. There were evidence weekly drug checks and six-monthly pharmacy checks were completed. There were no standing orders used at the time of audit. Medications are checked against the doctor's medication profile on arrival from the pharmacy by a RN. Any errors by the pharmacy are regarded as an incident and referred to the pharmacy. Medication charts reviewed demonstrated medication profiles were up to date, with as required (PRN) medicines prescribed in line with legislation, protocols and guidelines. Three-monthly reviews are conducted by the GP and any discontinued medicines are dated and signed by the GP. Documentation of administration was completed in line with legislative requirements. Medication administration observed met legislative requirements. There is a policy and process that describes self-administered medicines. There are currently two residents who self-administer inhaler medication. The residents' competencies are checked three-monthly and a record signed by the GP is kept on file.
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	A full-time chef/kitchen manager with over 30 plus years' experience in the food industry, oversees food provision at Woburn. The chef is supported by a second cook and two kitchen assistants across seven days. All staff working in the kitchen had completed food safety training. The service has a large commercial kitchen. There is a current food control plan available in the kitchen with the last verification completed in June 2019. Corrective actions from the verification regarding equipment had been implemented and signed off by the verifying agent. The kitchen and the equipment meet food safety requirements. Fridge/freezer temperatures are checked and documented three times daily and maintained within the required temperatures. Food in the fridges was observed to be covered and dated. The kitchen was clean, and all food was stored off the floor. A cleaning schedule is maintained. Chemicals are stored appropriately. Food audits are carried out as per the yearly audit schedule. There is a four weekly seasonal menu last reviewed by a dietitian at organisational level in March 2019. The service encourages residents to express their likes and dislikes. The kitchen can cater to specific requests if needed. Diets are modified as required. At interview the chef described that a RN completes each resident's nutritional profile on admission with the aid of the resident and family as applicable, and the kitchen is notified daily of any changes. Meals are plated in the kitchen and delivered to the main dining room and dementia area kitchen via bain-maries to maintain correct food temperatures. End cooked, hot holding and prior to serve temperatures are

		recorded. Residents requiring extra support to eat, and drink are assisted, this was observed during lunch. The residents interviewed spoke highly about the meals provided and that staff ask about their preferences.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If a referral is received and the prospective resident is declined entry to the service, the local needs assessment and service coordination service and/or referring agency is advised. The resident and/or family/whānau are supported to find an alternative arrangement. The residents would be declined entry if not within the scope of the service or if a bed was not available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	InterRAI assessments are completed within the required timeframes and available to staff. InterRAI assessments were sighted in all long-term resident files reviewed during the on-site audit. Needs identified in the interRAI assessment process were reflected in PCCPs in resident files reviewed. The respite resident's needs had been assessed and informed their respite care plan. Residents, their families and the GP interviewed, were satisfied with the care provided at the facility.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Residents' PCCPs reflect current conditions as identified through the interRAI assessments. The PCCPs include residents' individual goals and needs as identified through the interRAI assessment process, with supporting interventions to guide staff in their service provision. All residents have current care plans in place to guide service delivery. The respite care plan contained all required information to inform care needs for this resident. The PCCPs evidence service integration with the progress records, activities record, medical and allied health notes clearly documented. Any change in care required is documented and verbally passed on to staff concerned. The PCCPs are completed in consultation with the resident and/or family/whānau. The PCCPs are signed by resident and/or family/whānau/EPOA where applicable, and the RN. Residents and families interviewed reported participation in care planning.
Standard 1.3.6: Service	FA	Registered nurses and HCAs follow the care plan and report progress against the care plan each shift at

Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		handover. The use of short-term care plans was evident. Monitoring forms, including but not limited to: weight; observations and wounds, are in use as applicable and maintained. In files sampled wound care plans, nutrition management, fluid balance management plans and pain management plans were evident. The service has adequate stock of wound and continence products. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g. to the wound care nurse specialist, physiotherapist or podiatrist). If external medical advice is required, this will be actioned by the GP. Interview with the CN confirmed the DHB wound or continence specialist nurses are contacted when required. There was evidence in files reviewed of the wound specialist referrals. The GP interviewed stated the facility implement changes of care in a timely manner and was satisfied with the quality of service delivery provided. Interviews with residents and their family confirmed their satisfaction with the care provided at the facility.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by the activity coordinator (AC). The activity programme aims to address the residents' needs, age and cultural preferences. The AC plans a monthly programme which is then made available to all residents and their families. Residents can attend any activity. The activities programme was reviewed and evidenced sign off by a diversional therapist. 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 activity assessment utilised. Adequate resources are provided by the AC to meet the needs of individual residents. Activities were observed during the days of audit with the AC providing activities in the dementia unit late afternoons. Residents help with garden projects and attend the rest home activities programme where possible. Interviews with staff and families confirmed residents enjoy activities offered such as music and visits from canine friends. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group and one-on-one activities are offered. Examples include craft activities, exercise classes, playing cards, newspaper reading, craft work, music sessions and van outings in the community. There is a vegetable garden cared for by one resident and the produce is supplied to the kitchen. Entertainment and visitors from the community are included in the programme. Residents also attend two shows a year outside the facility, with four residents recently attending a local show. Attendance records are maintained. The AC interviewed discussed the activities and social assessment which is completed when residents are admitted. Resident files reviewed evidenced each resident's activities assessment includes previous and current interests and abilities. The residents' activity needs are

		evaluated six monthly or more often if required. Resident meetings are held regularly, and residents' input is sought and responded to. Residents interviewed stated they find the programme enjoyable and interesting.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Review of PCCP documentation, observations and interviews with staff and residents confirmed the residents received care according to assessed needs. There was documented evidence that all PCCPs reviewed had been completed within timeframe required or updated when there was a change in health status. Three of three PCCP requiring review evidenced at least six-month reviews were completed. An additional two residents' files had not been at the facility long enough to require review and the sixth resident file reviewed was for respite care. Formal evaluations document progress against resident goals and needs as identified in the PCCP. The evaluations are signed and dated and there is evidence of family/whānau EPOA involvement. The GP reviews residents' medication at least three-monthly or more often if issues arise or health status changes. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews. Progress notes record entries each shift and document changes in condition and outcomes of interventions. Short-term care plans are in place for acute problems. Family and residents interviewed confirmed they are kept up to date with any changes in health condition and are involved in evaluations.
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	The service facilitates access to other medical and non-medical services. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the DHB. There are four resident doctors, however, residents may choose to use another medical practitioner if they so wish. The GP interviewed discussed the referral process and when required sends a referral seeking specialist input for a resident. Copies of referrals and associated documentation were reviewed in residents' records, including referrals to inpatient services at the DHB, medical specialists and other services. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending a resident to emergency department in an ambulance if required.
Standard 1.4.1: Management Of Waste And Hazardous	FA	Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements

Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		for clear labelling and disposal of and collecting waste. The hazard register is available and current. Current material safety data posters are available and accessible to staff in relevant places in the facility, for example, the sluice and cleaning cupboard. The product supplier provides training in the safe use of chemicals. Staff receive training and education in waste management and infection control as a component of the mandatory training. Interviews and observations confirmed that there is enough personal protective clothing and equipment provided, such as aprons, gloves and masks. Interviews confirmed that the use of personal protective clothing and equipment is appropriate to the recognised risks. Observation confirmed that personal protective clothing and equipment was used in high-risk areas.
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 in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation. A preventative and reactive maintenance schedule is implemented. This includes monthly maintenance checks of all areas and specified equipment such as hoists. Staff identify maintenance issues in a maintenance log book. These are reviewed daily by the maintenance person. Urgent requests are attended to as required. A review of maintenance requests and interviews confirmed staff awareness of the processes for maintenance requests and that repairs were conducted in a timely manner. Interviews with staff and visual inspection confirmed there is adequate equipment available to support care. The facility has an annual test and tag programme that is up to date. Evidence of checking and calibration of biomedical equipment was sighted. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained. Van safety checks are undertaken and include for example: tyres; oil; hoist; and first aid kit. Inspection confirmed the van has a current registration, warrant of fitness, first aid kit, extinguisher and functioning hoist. Interviews with staff interviews and documentation evidenced that those staff who drive the van have a driver's licence and complete annual van driving and competency assessments, such as but not limited to: undertaking pre-set off checks; vehicle loading and parking. Hot water temperatures are assayed monthly and are maintained within recommended temperature ranges. A review of temperature assays and interview with the maintenance person confirmed that where hot water temperatures have been above the recommended safe temperature, action is taken, and rechecking of the temperature occurs to ensure a safe temperature is maintained. All resident areas can be accessed with mobility aides. There is a secure fenced grassed area as well as an internal court yard that are accessible from the dementia unit. Observation and interviews with family confirmed that residents can move freely around the dementia unit and that the accommodation meets their

		needs. There are grassed and paved areas accessible from the rest home. The external areas in both the rest home and dementia areas have outdoor seating and shade and can be accessed freely by residents and their visitors.
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 sufficient accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility. There is one room with a full ensuite and the remaining rooms have access to shared toilet and bathroom facilities. Communal toilets have a system to indicate vacancy and have disability access. There are two visitor toilets located at each end of the rest home, one of which is close to the dementia unit. All shower and toilet facilities have call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence. Residents were observed being supported to access communal showers in a manner that was respectful and preserved the resident's dignity.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Residents have their own room, and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Interviews with residents and family and observation confirmed that there was enough space to accommodate: personal items; furniture; equipment and staff as required. Residents and their families can personalise the resident's room. Furniture in residents' rooms include residents' own personal pieces and memorabilia; is appropriate to the setting and is arranged in a manner that enables residents to mobilise freely. There are designated areas to store equipment such as wheel chairs, walking frames, commodes and hoists, tidily.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible	FA	There is a dining room and adjoining lounge in the dementia wing. The rest home has a separate lounge and dining room at opposing ends of the wing. All internal communal areas have seating and external views. Areas can be easily accessed by residents, family and staff. There are areas that are available for residents to access with their visitors for privacy if they wish. Observation and interviews with residents and family confirmed that residents can move freely around the facility and that the accommodation meets residents' needs.

areas to meet their relaxation, activity, and dining needs.		There are areas for storing activities equipment and resources. In each wing the lounge areas are used for activities. Residents were observed to have their meals with other residents in the communal dining rooms.
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	Facility laundry, including residents' personal clothing, is completed on site. Colour coded, covered laundry trolleys and bags were observed to be used for transport. There are two laundry assistants who work over night shifts and provide services seven days a week. Household staff interviewed confirmed knowledge of their role including management of any infectious linen. There is clear delineation and observation of clean and dirty areas. Where issues relating to missing residents clothing had been identified, corrective actions had been implemented to resolve these. Interviews of residents and family members and staff identified that the laundry standard met resident requirements. A cleaner is on duty each day, seven days a week and cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemicals on a trolley when cleaning and is aware of the need to keep the trolley with them at all times. Staff receive training in correct use of cleaning products. There is a sluice room available in each wing for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility with alcohol gels in various locations. The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Resident and family interviews, resident surveys and observation noted the facility to be clean and tidy.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Staff files and training records demonstrated that orientation and annual training includes emergency and disaster procedures and fire safety. An approved fire evacuation plan was sighted. Interviews with staff and review of documentation confirmed that fire drills are conducted at least six monthly. There is a sprinkler system installed throughout the facility and exit signage displayed. Training records confirm that staff have undertaken fire training. There is a nominated fire warden on each shift for each area. The staff competency register evidenced that 24 staff have current first aid certificates. This includes: the BCM; RNs; HCAs; and the AC. There are at least two staff members on each shift with a current first aid certificate. The facility has sufficient supplies to sustain staff and residents in an emergency situation. Alternative energy and utility sources are available in the event of the main supplies failing. These include: a barbeque

		and gas bottles; emergency lighting; and enough food, water, and continence supplies. The service's emergency plan includes considerations of all levels of resident need. Call bells are available to summon assistance in all resident rooms and bathrooms. Call bells are checked monthly by the maintenance person. Observation and family interviews confirmed that call bells are answered promptly. Security systems are in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building and the facility being locked in the evenings with restricted entry, through ringing a call bell at the front entrance afterhours. Staff receive training in security as part of the annual training programme.
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	All residents' rooms and communal areas accessed by residents have safe ventilation and at least one external window providing natural light. The facility is heated by wall panel heaters. The environment in all areas was noted to be maintained at a satisfactory temperature for residents. Systems are in place to obtain feedback on the comfort and temperature of the environment. Observation and interviews with residents and families confirmed that the environment was maintained at a comfortable temperature and there were no issues identified with the temperature of the facility. The facility has a designated external smoking area. At the time of the audit there were no residents who smoked.
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	Woburn rest home implements the Oceania infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The infection control programme is reviewed annually. The newly appointed CN has overall responsibility for the infection control programme and is the infection control nurse (ICN). The infection control committee has representatives in each area of the service team. This group meets monthly and infection control matters are discussed at the facility monthly quality and staff meetings. Meeting minutes are available for staff. Spot audits are conducted and include hand hygiene and infection control practices. Observation and interviews with staff, residents and families confirm there are measures in place to prevent exposure to infection.

Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICN is supported by the BCM and clinical quality manager. The ICN has infection control experience from their previous roles. The ICN has also 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 ICN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The ICN confirmed the availability of resources to support the programme and is aware of the need to analyse data and the reasons behind this.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual includes a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection control policies link to other documentation and uses references where appropriate. Infection control policies are reviewed as part of the policy review process by Oceania.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICN has completed relevant infection control training. Interview with the ICN confirmed they are aware of their responsibilities for training staff in all infection control matters. Staff complete formal infection control education at orientation and via Oceania study days. Training on infection control has been provided in 2019. Informal education is also provided and includes, but not limited to: hand hygiene and standard precautions. Resident education occurs as part of providing daily cares.
Standard 3.5: Surveillance Surveillance for infection is	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The internal process monitoring is undertaken via the internal audit programme. The service submits data monthly to Oceania support office where the data is benchmarked with other services in the

carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		organisation. When an infection is identified, a record of this is documented on the infection reporting form used by the service provider. The ICN is responsible for review of the reported infections. Infections are collated monthly. There are low numbers of infections recorded since previous audit. This data is analysed for trends and the results of surveillance are shared with staff via staff meetings (minutes sighted) and at staff handovers. There have been no infection outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The Oceania restraint minimisation and safe practice handbook and policies comply with the standard and relevant legislation. The restraint coordinator is the BCM. A signed position description is in place. There were no residents using restraints or requesting the use of an enabler during the on-site audit. Interviews with staff confirmed their understanding that enabler use is voluntary, requested by the residents and the least restrictive option to promote a resident's independence and safety.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.