

Oceania Care Company Limited - Lady Allum Rest Home and Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Oceania Care Company Limited
Premises audited:	Lady Allum 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: 13 April 2021 End date: 14 April 2021
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:	85

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

Lady Allum Rest Home and Village provides rest home and hospital level care for up to 87 residents. The service is operated by Oceania Healthcare Limited and managed by a business and care manager and two clinical managers. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, managers and staff and a general practitioner.

The audit has resulted in three continuous improvement ratings related to adverse event reporting, the activities programme and safe and appropriate environment relating to the laundry service. Two areas were identified as requiring improvement related to service delivery planning and evaluation of the care plans.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service provides care that reflects the Code of Health and Disability Services Consumer Rights (the Code). Information about the Code is promoted and shared with residents, family/whānau members and staff. Residents are encouraged to maintain cultural customs and connections with their community. Care and support are delivered in line with good practice. Residents and family/whānau advised that the service treats them with dignity and respect.

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

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

The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Oceania Healthcare Limited is the governing body and is responsible for the service provided at the facility. A business plan and quality and risk management plans are documented and include the scope, direction, goals, values and mission statement of the organisation. Robust systems are in place for monitoring the services provided including regular daily, weekly and monthly reporting by the manager to the governing body. A national clinical governance team is established for the organisation and this involves input from the business and care manager and the two clinical managers at Lady Allum Rest Home and Retirement Village.

The facility is managed by an experienced and suitably qualified business and care manager who is a registered nurse.

A quality and risk management system includes an annual schedule of internal audits activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident, family and staff satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where applicable. Meeting minutes, graphs of clinical indicators and benchmarking results are available and were reviewed. Corrective action plans are developed, implemented, monitored and signed off when completed. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated, and the hazard register is current and up to date.

A suite of policies and procedures cover the necessary areas, were current and reviewed regularly by the organisation's quality compliance team at Oceania support office.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation/induction and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan, facilitate and record ongoing training supports safe service delivery, and includes regular individual performance review.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents are met. There is an on-call after-hours system in place.

Residents' information is kept securely with all entries legible and designated.

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.
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Access to Lady Allum Rest Home and Village is efficiently managed by the admissions coordinator with relevant information provided to the potential residents.

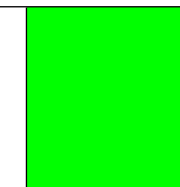
The process for assessment, planning, evaluation, and exit are provided by suitably qualified staff. InterRAI assessments and care plans are individualised and based on a comprehensive range of information and accommodate any new problems that might arise. Files sampled demonstrated that the care provided and needs of residents are reviewed on a regular basis. Residents are referred or transferred to other health services as required.

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

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

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed, and snacks and drinks are available on a 24-hourly basis. There is a current food control plan.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has been purpose built. There are single rooms and care suites available. All rooms are of an adequate size to provide personal cares.


All building and plant comply with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented. The service is undergoing a major reconstruction project which is being managed safely.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas in appropriate locations are available with appropriate seating for residents.

Implemented policies and procedures guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. Most laundry is undertaken off site with the exception of residents' personal clothing which is done on site. The laundry system is monitored to evaluate effectiveness. Cleaning is managed on site, meets all requirements, and is linked to health and safety and infection prevention and control.

Emergency procedures are documented and displayed. Regular six-monthly fire drills are completed and there is a sprinkler system, smoke detector system and call points installed in case of fire. Emergency lighting is available and is checked monthly. Emergency stores are available. Residents reported a timely staff response to the nurse call system in place. Security is managed effectively onsite.

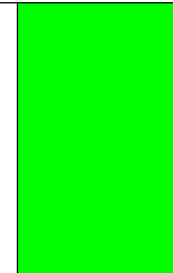
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Five restraints were in use. Restraint is only used as a last resort when all other options have been explored. Enabler use is voluntary for the safety of residents in response to individual requests. Staff interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by the infection control coordinator, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. There have been no infection outbreaks reported since the last audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	47	0	2	0	0	0
Criteria	3	96	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Lady Allum Rest Home and Village has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The interviewed staff understood the requirements of the Code and were observed communicating with residents in a respectful manner, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The interviewed RNs and care staff understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Informed consent has been gained appropriately using the organisation's standard consent forms. Signed consent forms were sighted in the clinical files reviewed. Activated enduring power of attorney (EPOA) documents were sighted where applicable. Staff were observed to gain consent for daily cares.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are given a copy of the Code, and information on the Advocacy Service as part of the admission information provided. Posters and brochures related to the Advocacy Service were displayed and available in the facility. Family/whānau and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. In interview, the CLs reported that independent advocacy can be accessed if required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Information on significant others and family/whānau is documented during the admission process and level of family involvement with family/whānau is discussed. Family/whānau contact records were sighted in the reviewed records.</p> <p>Visiting is unrestricted and residents' family/whānau and friends of choice can visit as desired. Family/whānau interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. A visitors' book is maintained for all visitors. Family/whānau were observed picking up their family member for community outings and support is provided for residents to access specialist appointments as required.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirement of Right 10 of the Code. There is also a flow chart developed and implemented to guide staff. The complaints information is provided to residents on admission and there is complaint information and forms at reception. A complaints/compliments box is also located in the reception area of the facility along with forms and pamphlets on the complaints process.</p> <p>The complaints register reviewed evidenced 17 minor complaints in the last twelve months. Actions were taken through to an agreed resolution, were fully documented and completed within the required timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible. One complaint was received from the Health and Disability Commissioner's office which was sent onto the Nationwide Consumer Advocacy Service and has been closed out. A further complaint received by the Ministry of Health in February this year was forwarded directly to the district health board (DHB). A full complaint investigation occurred, and a copy of the complaint was sent to the regional operations manager (now called the regional care manager). Correspondence with the business and care manager, clinical manager and emails to relevant staff resulted in a meeting being arranged with the contracted food service provider as the complaint was related to the food service. An arranged unannounced audit by the Oceania National Catering Manager was arranged. A meeting with the family concerned was also arranged to provide feedback. A review of the food</p>

		<p>service contract occurred, and a conclusion was to be reached by Oceania support office management team. On the day of the audit an email confirmed that the contract will cease, and Oceania will manage the food service at Lady Allum Rest Home and Village.</p> <p>One week before this audit a complaint was received anonymously to the MoH and has been directed to the district health board. The business and care manager demonstrated extensive knowledge in managing complaints and processes are being followed as required and this complaint remains open at the time of audit.</p> <p>The complaints management system has been significantly improved and the business and care manager is transitioning to a new electronic system being introduced across the organisation nationwide. Monthly monitoring of all complaints occurs and is covered with information being provided on the analysis process, identification of any trends and information is included in the monthly reports and reported to the newly appointed quality compliance and audit manager (QC&AM). Staff training is provided on complaints management at least two yearly.</p> <p>The complaints register was current and up-to-date. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed at the reception area together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Services are provided in a manner that respects residents' dignity, privacy, sexuality, spirituality and choices. The interviewed residents and families confirmed this. Personal care was provided behind closed doors throughout the audit days. All residents have their own private room.</p> <p>Residents are supported to maintain their independence where appropriate, for example, when attending to community activities and participation in activities of their choosing. Care plans included documentation related to the residents' abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. Interviewed family, residents and a general practitioner (GP) have not witnessed or suspected any abuse.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs as desired by individual residents. The principles of the Treaty of Waitangi are incorporated into daily practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents' individual culture, values and beliefs were identified on admission during the admission assessment. Interviewed residents and family/whānau confirmed that they were consulted on individual values and beliefs and staff respected these. Residents' personal preferences required interventions and special needs were included in the care plans reviewed. The resident satisfaction survey confirmed that individual needs were being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents, family members and the general practitioner (GP) interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. These are included in the employee handbook and are discussed with all staff during orientation period. The registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, diabetes nurse specialist, wound care specialist,</p>

<p>Practice</p> <p>Consumers receive services of an appropriate standard.</p>		<p>mental health services for older persons, and education of staff. The annual education planner included mandatory training topics. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Online education sessions are promoted for all staff throughout the organisation.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family/whānau stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are accessed through the local DHB, although the clinical managers (CLs) reported this was rarely required due to most residents able to speak English; staff able to provide interpretation as and when needed; the use of family members and communication cards for those with communication difficulties.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>There is a business plan and quality and management plan for 2021 that is documented for Lady Allum, Rest Home and Village. A mission statement, statement of purpose and the philosophy of the service is clearly documented. Quality and risk planning is clearly documented with goals and objectives covering provision of quality services appropriate to the needs of the residents, to improve the quality of life of residents, to provide and maintain a safe and healthy environment in the home and to provide a cost effective service that gives value for money while organising resource constraint.</p> <p>The business and care manager (BCM) interviewed reports to the newly appointed quality compliance and audit manager (QC&AM) weekly about any issues or concerns that have been highlighted within the services provided. Staff in the weekend inform the registered nurse and/or the clinical manager of any emerging risks or issues as required.</p> <p>The service is managed by a business and care manager who holds relevant qualifications in healthcare. The manager has been in this role for three and a half years and has worked in the aged care industry as a consultant and in nursing management for many years working both in New Zealand and Australia. The BCM is suitably skilled and experienced for the role and the responsibilities and accountabilities as defined in the job description reviewed. At interview, the BCM confirmed comprehensive knowledge of the aged care sector, regulatory and reporting requirements and maintains currency through ongoing management and nursing education as per the training records. The BCM is well supported by the clinical manager and the regional clinical manager. A team of reception and administration staff also provide support to the BCM, residents and</p>

		<p>families.</p> <p>The service holds contracts with the DHB for rest home level care, hospital level – geriatric and medical, respite, younger persons with a disability (YPD) long term support chronic health care (LTSCHC). On the day of audit 85 residents were receiving care; one younger persons with a disability (YPD). Two LTSCHC hospital, two respite, 23 rest home level care and 57 hospital level care and one resident in the DHB hospital.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The BCM manages the day-to-day operation of the service. When absent from the facility, there are two clinical managers available to cover and to continue to provide all clinical input. One of the two clinical managers, with support of administration team and the regional care manager, can manage the business and non-clinical issues.</p> <p>The management team are able to carry out all the required duties under delegated authority. The quality compliance and audit manager is also able for advice and support. Support office staff are available to contact regarding any issues that may arise.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The BCM and the two clinical managers are aware of the business and quality plans and those interviewed had a good understanding of the processes in place. The quality and risk system in place reflects the principles of continuous improvement. This includes the management of audit activities including regular resident, staff and family satisfaction surveys, monitoring of outcomes and clinical incidents, including restraint minimisation and safe practice, health and safety, infection prevention and control management.</p> <p>The organisation acknowledges the Health and Safety at Work Act 2015 and ensures all requirements are met to adhere to defined safety procedures and practices. Employees are to conduct themselves in a manner that avoids harm to themselves and others. The health and safety committee exists for the purpose of implementing, maintaining and monitoring a safety programme for residents, staff and visitors to the facility. Staff input is encouraged. There is a designated health and safety coordinator whose authority and accountability for safety related matters is clearly defined. A new National Safety and Injury Advisor for Health and Safety has been appointed (April 2021) for Oceania and will cover all facilities for this organisation.</p> <p>Hazards are identified and documented. The BCM described the identification, monitoring and reporting of any risks and the development of mitigation strategies. The risk register is reviewed at least annually. New risks are added to the register following a documented process. The register was current and up to date. There are detailed procedures to show that health and safety is managed to meet the legislative requirements.</p>

		<p>Terms of reference and meeting minutes reviewed confirmed efficient reporting occurs and action is taken as needed. Outcomes are compared from the previous year and for benchmarking purposes. Regular review and analysis occur, and related information is reported monthly and discussed at the quality and staff meetings. Minutes maintained were available for review. Discussion occurs on pressure injuries (if any), restraints, falls, complaints, adverse events, infections, wounds, audit results and the activities programme.</p> <p>Staff interviewed stated they were involved in quality and risk activities through participating in the internal audits. The 2021 quality audit schedule was reviewed and audits were completed appropriately in a timely manner as required. Corrective action sheets are developed and implemented and demonstrated a continuous process of quality improvement is occurring.</p> <p>Surveys are sent out to residents/family members three months after the resident is admitted. Another survey at six months is arranged by the support office. Staff annual surveys are also completed. Outcomes are reported for each facility from support office when data is analysed for quality improvement purposes. Results evidenced that families were satisfied overall with the services provided. Outcomes of surveys and internal audits were compared with the previous year's outcomes and a summary was completed with any recommendations, if they required any action to be taken, by whom, and were signed off when completed and dated. Any areas of quality improvement were discussed at the staff meeting. The newly implemented regional clinical manager's clinical newsletter is a new initiative to provide regional updates about service provision highlights, quality management feedback, health and safety information and to provide a record of all updated or newly implemented policies and procedures, every two months. This has been well received by staff interviewed.</p> <p>Policies and procedures reviewed cover all aspects of the service and contractual requirements and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. A quality compliance and audit team at support office review and update policies and procedures. Once signed off by the support office team, staff are updated on new policies or any changes to policies through the staff meetings, newsletters and memorandums through the electronic pay system and/or on the staff notice board.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their</p>	<p>FA</p>	<p>Staff document adverse events and near miss events on an accident/incident form. A sample of incident forms reviewed showed these are fully completed, incidents are investigated any action plans are developed and actions are followed up in a timely manner. Adverse event data is collated, analysed, and reported to staff at the staff/quality meetings. Minutes reviewed showed discussion in relation to any trends identified, action plans in place and any/or improvements made. The service is transitioning from hard copy records to an electronic system and staff are being trained to be proficient in entering the appropriate data needed. The system is linked with the electronic care system in place which will be beneficial. Medical input has been sought from the general practitioners to ensure all instructions for medical reasons will be able to be carried out and followed up as well.</p> <p>Policy and procedures described essential notification reporting requirements. There were six Section 31</p>

family/whānau of choice in an open manner.		<p>notices completed in 2020 to HealthCERT. The BCM and the two clinical managers interviewed are fully informed of what agencies to report to when a serious/notifiable event occurs. A continuous improvement is made for the high standard of documentation by the BCM in regards to adverse, unplanned or untoward events occurring and the using of these opportunities and outcomes to improve service delivery and to identify and to manage risk at the facility.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Policies and procedures reviewed are in line with good employment practice and relevant legislation and guide human resources management processes. Job descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates where applicable. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained. Checklists are noted on the records reviewed. There is a process for managing the annual practising certificates for all health professionals employed or contracted.</p> <p>Staff orientation includes all necessary components relevant to the role. Employee handbooks are completed and/or competency packages for clinical and non-clinical staff as needed to cover all mandatory education and topics relevant to the individual employee. Staff interviewed reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Most staff interviewed had been at the facility for some years. Staff records reviewed show documentation of completed orientation and a performance review (appraisal) is completed annually.</p> <p>Staff interviewed enjoyed working at the facility and stated that educational opportunities are provided. Continual education is planned on an annual basis. Mandatory training requirements are defined and scheduled to occur over the course of the year with the Oceania 'Growth education motivation' (GEM) study days. All forty healthcare assistants (HCAs) and some non-clinical staff have either completed or have commenced a New Zealand Qualifications Authority education programme to meet the requirements of the provider's agreement with the DHB. Currently of the 40 HCAs there are four level one, two level 2, five level 3 and twenty-nine (29) have completed level 4. The administration manager is responsible for the staff records and was interviewed. The clinical manager is the assessor onsite at this facility. Twelve (12) of 13 registered nurses are fully trained and competent with interRAI assessments.</p> <p>The education programme also provides topics pertaining to managing younger persons with disabilities (YPDs) and this is also addressed in the YPD residents' recreational plans reviewed.</p> <p>Appraisals were current for all staff. All senior health care assistants and registered nurses have completed and have current first aid certificates. Annual staff competencies were completed and all senior care staff who administer medicines have completed annual medicine competencies which were recorded.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of the residents. The BCM explained that health care assistants and registered nurses are now rotating around the facility as per the electronic rostering system rather than staying on set shifts. The rosters are developed and implemented for the six-week period. This process is currently under review by the support office team. This ensures that staff get to know residents on other wings and staff are then more flexible when covering the service areas. Continuity of service delivery is promoted and teamwork is encouraged.</p> <p>An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>Care staff reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a six-week roster cycle sampled during the audit confirmed adequate staff cover has been provided.</p> <p>At least one staff member on a shift has a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The service has transitioned from a paper-based information management system to electronic system in November 2020. This includes interRAI assessment information entered into the Momentum electronic database. Most of the residents' information is in the new electronic management system except for the admission information, admission agreements and consent forms. Residents' files reviewed were comprehensively documented including all the necessary demographic, clinical and health information.</p> <p>All information is maintained in a secure manner with staff having individual login passwords to the electronic system. Personal information, other than a name on the residents' bedroom door, was not publicly accessible. Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Records were integrated. Allied providers completed entries in the residents' electronic files. These included entries made by the activities staff, the GP, nurse practitioner and physiotherapist.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need</p>	<p>FA</p>	<p>The admissions coordinator is responsible for coordinating the admission of residents into the service. Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. NASC documents were sighted in the reviewed residents' records. The organisation seeks updated information from the NASC and the GP/nurse practitioner for the residents accessing respite care.</p>

<p>for services has been identified.</p>		<p>Family/whānau interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments, and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The RNs and the clinical managers are responsible for managing the exit, discharge, or transfer in a planned and co-ordinated manner, with an escort provided as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to acute care services. The 'ISBAR' communication tool is promoted to allow an effective communication and transfer process for residents. There was open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information was provided for the ongoing management of the resident. Referrals were documented in the progress notes sampled. An example of a resident recently transferred to the local acute care facility showed adequate documentation was completed. Family/EPOA of the resident reported being kept well informed during the transfer of their relative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family/EPOA. Examples of this occurring were discussed. There is a clause in the admission agreement related to when a resident's/consumer's placement can be terminated.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and meets the legislative requirements.</p> <p>A safe system for medicine management using an electronic system was observed on the days of audit. The electronic system is accessed using individual passwords. The RNs were observed administering medication correctly. They demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage and had a current medication administration competency. The electronic prescribing practices included the prescriber's name and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The three-monthly medication reviews were consistently recorded on the electronic medicine charts sighted.</p> <p>The service uses pre-packaged medication packs which are checked by the RNs on delivery. The medication was stored safely, and medication reconciliation is conducted by RNs when a resident is transferred back to the service from any hospital admission. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly and on request.</p>

		<p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room sampled were within the recommended range. There was no food stored in the medicine fridge. There were no vaccines kept on site.</p> <p>There was a resident who was self-administering eye drops at the time of audit. Appropriate processes and documentation were completed.</p> <p>The clinical managers reported that a comprehensive analysis of any medication errors is completed when required as guided by the medication management policy.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by external contractors and is in line with recognised nutritional guidelines for older people. There is one qualified chef and two cooks. Kitchen staff have completed relevant food handling training. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the past two years. The food service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries (MPI). A food verification audit was completed on 17 March 2020 and recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, were monitored appropriately and recorded as required. The kitchen and pantry were clean on the days of the audit. There was no expired food in the pantry. All the decanted food and cooked food in the fridge were covered and labelled. The kitchen manager reported that no food is reheated. Fridge and freezer temperatures were recorded.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Current copies of the dietary profiles were sighted in the kitchen records sighted. Special equipment, to meet resident's nutritional needs, was available.</p> <p>Some residents reported dissatisfaction with the meal service and the business and care manager was aware of their concerns and corrective actions were being implemented to address the issues of concern (Refer criterion 1.1.13). The business and care manager reported that feedback on the food services is sought from residents and family through satisfaction surveys and residents' meeting. This was verified in the meeting minutes reviewed. Residents were given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The admissions coordinator reported that if a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. Enquiries are received by email, phone or 'walk in'. A preadmission assessment form is completed to assess if the prospective resident meets the entry criteria. The admissions coordinator follows up on all enquiries and records were maintained.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and interRAI, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and family/whānau confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Care plans reviewed reflected the support needs of residents and other relevant clinical information. Identified behaviours of concern are not documented on the behaviour care plans.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and family/whānau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The reviewed documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident in all areas of service provision. The interviewed GP confirmed that medical input was sought in a timely manner and that medical orders are followed, and care is implemented promptly. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The activities programme is provided by two trained diversional therapists (DT) holding the national Certificate in Diversional Therapy, and three activities coordinators. The activities are provided every day of the week including weekends. The activities are held separately in the three wings, and residents are able to attend to any activities in other wings.</p> <p>A social assessment and history assessment is completed on admission by the DTs to ascertain residents' needs, interests, abilities, and social requirements. The weekly activities plan is given to each resident and posted on the notice boards around the facility. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated six-monthly as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. The activities on the programme included bowls, music, church services, external entertainers, quiz, puzzles, walks, van outings, birthday celebrations, newspaper story discussions, men's club, "Remember me" and virtual reality project, and exercises. The hairdresser is available twice per week for hairdressing.</p> <p>Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Daily activities attendance records were maintained, and residents were observed participating in various activities on the days of the audit. The interviewed residents confirmed they find the programme satisfactory. The younger residents had planned activities appropriate for their age and abilities. They can join in the group activities if desired and they expressed satisfaction with their planned activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Resident care is evaluated on each shift and reported in the progress notes on each shift by the care staff. RNs document daily. Changes noted were reported to the RNs. This was confirmed in the progress notes reviewed.</p> <p>Care plan evaluations and interRAI reassessments were completed six-monthly or as residents' needs change. The required process of evaluating the care plans following the interRAI reassessments was not completed consistently. Where progress was different from expected, the service responded by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for eye infections, skin and chest infections. Unresolved problems were added to long-term care plans. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner if desired. If the need</p>

<p>Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to urologists, eye specialists and wound care specialists. The interviewed residents and family/whānau confirmed they were kept informed of the referral process, as verified by documentation. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances were in place. A contracted service is responsible for collecting waste at timeframes that are pre-arranged which is three times a week. The hazardous substance register was sighted and reviewed and updated last on 21 January 2021. This is signed off by the National Compliance Manager Oceania Group. The hazard register covers all chemicals used at this facility, care provision hazards, outside the premises hazards, laundry and cleaning hazards and any kitchen hazards.</p> <p>The doors to the areas storing chemicals were secured and containers labelled. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew how to access information if needed. The maintenance manager has been employed at this facility for seven years and ensures the supplies needed are available for the laundry and the cleaning staff to use. A spills kit is available should an event occur. Any related incidents are reported in a timely manner.</p> <p>There is adequate provision and availability of personal protective clothing and equipment (PPE) and staff were observed using this, including gloves, goggles, masks and gowns as needed. The contracted company representatives are responsible for ensuring adequate stocks of PPE are ordered and available for staff at all times. A cupboard is available with stores of PPE resources for use in the event of an infection pandemic.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their</p>	<p>FA</p>	<p>A building warrant of fitness which expires 15 March 2022 is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio-medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Improvements have been made to the inside of the facility and to the outside since the previous audit. Furniture and furnishings are replaced as needed. A major building project is currently under construction. This</p>

purpose.		<p>construction is totally separated and safe from the care services. The planned opening is March 2022.</p> <p>External areas are fully maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the designated areas. All efforts are made to ensure the environment is hazard free and that residents are safe at all times. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. The hot water checks are documented. Samples are measured from the tap and the hot water temperature cylinder readings obtained. If any variances from requirements occur the preferred contracted plumber is contacted.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is a mix of toilet, showers and bathing facilities. The care suites have their own ensuite bathrooms. There is a hand basin and toilet in all individual rooms. There are adequate numbers of accessible bathrooms and toilets throughout the facility including visitors and staff toilets. All residents' rooms have a hand basin in their room.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence, such as shower chairs and/or hoists if needed. There is also a shower for staff to use, when pandemic planning is in place. Equipment, such as shower chairs and hoists, are available as needed.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move within their bedrooms safely. There are no shared rooms. Rooms are personalised with ornaments, photographs and other personal items displayed.</p> <p>There is adequate space to store mobility aides, walking frames, a variety of hoists, shower chairs and wheelchairs.</p> <p>Staff and residents reported adequacy of individual bedrooms. All furniture is provided if residents do not have their own furniture.</p> <p>A variety of beds were sighted (eg, high low and hospital beds). Armchairs, 'fall out' chairs and lockers are provided. Safety is maintained as residents' individual rooms are mostly spacious in size and equipment can be utilised if necessary to maintain a homely environment and to maintain residents' independence.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are communal areas available for residents to engage in activities. There are three large lounges and four dining rooms available. Lounge and dining areas are spacious and enable easy access for residents and staff. A large screen television is available in a separate large lounge available for the activities programme and comfortable seating. Residents are able to access areas for privacy. There is a large courtyard and raised gardens in one of the larger care settings at this facility. Furniture is appropriate to the setting and residents' needs. It is arranged in a manner which enables residents to mobilise freely. Bookshelves are evident with ex-library books for residents to access anytime in the small lounges.</p> <p>The grounds at the front of the facility are well utilised as there is adequate seating outside for residents to enjoy the garden and people coming in and out of the facility.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is now undertaken off site. Staff are employed to undertake laundry duties and ensure all laundry is packed in the linen bags in readiness for collection by the contracted service providers as arranged. The staff are responsible for the residents personal clothing only and this is washed and is distributed out to residents daily. Trolleys are used for this purpose and this system is working effectively. The laundry person and one assistant cover the service seven days a week. Residents/family interviewed reported that laundry is now well managed and their clothes are returned in a timely manner. The laundry is set up to meet the needs of the residents. Previously all laundry including the personal clothing was done at another Oceania site; however, permission was granted from support office for a temporary laundry to be set up when the pandemic was in place last year and also because of many complaints about missing clothing during this time. This temporary laundry is divided into dirty and clean areas for infection prevention and control purposes, is well ventilated, clean and tidy in appearance. A continuous improvement rating is made for this quality initiative.</p> <p>There are combined policies and procedures for the laundry and cleaning which meet the infection control standards. There are clear job descriptions for both roles. Each resident has a basket for all clean personal clothes to be placed in before being returned to their individual rooms.</p> <p>There are cleaners rostered on duty seven days a week. All cleaners have job descriptions. The cleaners' trolley is stored appropriately and safely when not in use. The maintenance person stated that the bottles are refilled as needed and all containers have the labels in place. The product representatives provide education for the domestic staff on a regular basis. Certificates for education were sighted in the staff records reviewed.</p> <p>Material data sheets are available and accessible as needed. The night care staff have a schedule to follow as do the day staff. The service is maintained to a high standard considering the service is undergoing a large reconstruction.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for all emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 6 April 2011 and remains operative. A trial evacuation takes place six monthly with a copy of the drill sent to the New Zealand Fire Service, the most recent drill being the 23 March 2021. The orientation programme for all newly employed staff includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures. Emergency training is provided on an ongoing basis. The service has upgraded the Tsunami emergency plan as part of the documentation control plan.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, torches, batteries and a gas barbecue were sighted and meet the requirement for 87 maximum residents for a minimum of three days. Emergency lighting is available. A water container of 1600 litres water is available. Bottled water is available. All supplies are checked monthly. There is a no generator on site but access to one is available if necessary. Oxygen cylinders are available for use as a back-up for an oxygenator if in use at the time of a power failure. The maintenance manager stated that the service has an agreement with a hire pool company that in the event of an emergency a large generator will be made available for this facility. All emergency supplies are checked regularly with one large bin also being available with all emergency resources needed in an emergency. Hot water temperatures are monitored monthly and were within the required range. The thermometer is calibrated annually.</p> <p>Call bells alert staff to residents requiring assistance. The nurse call is connected to the health care assistants' pagers. Call system audits are completed on a regular basis with both visual and activation tests being undertaken and residents and families reported that staff responded promptly to call bells.</p> <p>The grounds are well maintained by a grounds person. A maintenance programme is in place and the record folder was sighted. Any issues are signed off and dated when completed. The maintenance manager is well organised and has a preferred provider list to contact appropriate personal as needed and in a timely manner.</p> <p>Staff ensure the facility is locked at a pre-determined time each evening and care staff do hourly rounds at night-time. Outside security lighting is available. A security company monitors the total site.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and</p>	<p>FA</p>	<p>The residents' individual rooms and communal areas have opening external windows with natural light and safe ventilation. The facility has ceiling heating which is thermostat controlled. Heat pumps are situated in the main dining and lounge areas. Areas visited were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained and heated appropriately.</p>

<p>an environment that is maintained at a safe and comfortable temperature.</p>		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Lady Allum Rest Home and Village has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external expert services. The infection control programme was last reviewed in July 2020.</p> <p>The clinical manager is the designated infection control coordinator (ICC), whose role and responsibilities are defined in the infection prevention and control job description. Infection control matters, including surveillance results, are reported monthly to the business care manager and regional quality manager, and tabled at the staff meetings monthly, infection control team meetings and national infection control meetings.</p> <p>There is signage at the main entrance to the facility that requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The interviewed staff understood these responsibilities.</p> <p>There was a Covid-19 pandemic plan in place and current information on infection control measures and contact tracing requirements were implemented.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICC has appropriate skills, knowledge, and qualifications for the role. She has attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>There is a designated infection outbreak room with outbreak stock and general use personal protective equipment. Adequate resources to support the programme and any outbreak of an infection were available on the days of the audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in March 2020 and include appropriate referencing. The infection control policies are accessible to staff kept in folders and electronically.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as</p>

<p>prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. The interviewed staff expressed knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation, and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified personnel and accessed through the organisation's online sessions. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance was maintained. Additional education was conducted during the Covid-19 pandemic.</p> <p>Education with residents was on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather.</p>
<p>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.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, the upper and lower respiratory. The ICC reviews all reported infections, and these are documented on the infection register. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. This was verified by the interviewed care staff.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. Graphs were produced that identify trends for the current year, and comparisons against previous month and this was reported to the business and care manager and the support office. Data is benchmarked externally with other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. Infection prevention and control internal audits are conducted regularly.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in this facility and demonstrated a sound understanding of the organisation's policies, procedures and practice. The clinical manager is the restraint co-ordinator and has been in this role since 18 March 2019. A job description for this role and responsibilities is clearly outlined.</p> <p>On the day of the audit five residents were using restraints. No residents were using an enabler. When enablers are used these are the least restrictive and are voluntarily at their request. The service has a robust process which ensures the on-going safety and well-being of the resident.</p> <p>Restraint is used as a last resort when all alternatives have been explored. The annual restraint review was recently performed in January 2021.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group made up of the manager, clinical manager, the general practitioner/nurse practitioner are responsible for the approval of the use of restraints and the restraint processes, as defined in policy. It was evident from review of restraint approval group meeting minutes, review of residents' records and interview with the coordinator that there are clear lines of accountability, that all restraints have been approved and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/relative/whānau/ involvement in the decision making (authorisation/consent form), as is required by the organisation's policies and procedures was on record in each case, use of a restraint or an enabler is included in the care planning process and documented in the electronic plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator's involvement and input from the resident's relative/whānau. The restraint coordinator interviewed described the documented process. Families confirmed their involvement. The general practitioner/nurse practitioner has involvement in the final decision on the safety of the use of the restraint.</p> <p>The assessment process identified the underlying causative factors and/or any history of restraint use (if any), the cultural considerations, alternatives and associated risks identified. The desired outcome was to ensure the residents' safety and security at all times. Completed assessments were sighted in the records of residents who</p>

		were using a restraint. Currently in use there are two bedrails and three chair briefs used for restraint. One resident uses two forms of restraint; the bedrail at night and a chair brief in the day time as necessary.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>Restraint is used safely and in the best interest of the resident. The use of restraint is actively minimised, and the restraint coordinator explained how alternatives to restraint are discussed with staff and family. Restraint is used as a last resort after all other interventions have been considered and de-escalation techniques are used appropriately. The service uses sensor mats and low beds as needed. When restraints are in use frequent monitoring occurs to ensure and to promote safety. The outcome of restraint use is documented. Records of monitoring reviewed had the necessary details and records are maintained electronically by the care staff. Access to advocacy is provided if requested and all processes ensure dignity and privacy is maintained at all times and respected. The restraint register is maintained and was current and up to date. The restraint coordinator is responsible for the register.</p> <p>Staff receive training at commencement of service and training is ongoing. Restraint and de-escalation training was held in 2020 and 2021 including challenging behaviour management. Records of training are documented in the training records and on the individual staff education records of attendance sighted.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' records showed that the individual use of restraints is reviewed and evaluated during the care plan and interRAI assessments undertaken six monthly. The restraint evaluations are also completed by the restraint approval group. Families interviewed confirmed their involvement and satisfaction with the restraint process. The evaluation covers all requirement of the restraint minimisation and safe practice standards including options to eliminate restraint use if possible, with all outcomes being achieved. The staff ensure the restraint policy is followed and all documentation is completed.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint reviews occur six monthly of all restraint use which includes all the requirement of the standard. Six monthly restraint reports are completed, and individual use of restraint use is reported to the quality and staff meetings monthly. Minutes of meetings were reviewed, and this confirmed this includes analysis and evaluation of the amount and type of restraint considered, the effectiveness of the restraint in use for each resident, the competency of the staff and the appropriateness of the restraint/enabler education provided and feedback from family, the GP/nurse practitioner, and staff. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes of meetings and interviews with staff and the restraint coordinator confirmed that the use of restraint has been actively reduced over the past year.

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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)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>The assessment process identified behaviours of concern via the interRAI assessments, and these were sighted in the assessments reviewed. However, the behaviour care plans did not define the behaviours of concern. Only the required interventions were documented in the behaviour care plans reviewed.</p>	<p>Seven out of ten behaviour care plans sampled did not have defined behaviours of concern documented. The care plan only had the interventions for the behaviours documented.</p>	<p>Provide evidence to demonstrate that the residents' identified behaviours of concern are documented in the behaviour management care plans.</p> <p>90 days</p>

<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>The service has transitioned from a paper-based information management system to electronic management system, including the care planning system. The transition was completed in November 2020 and all care plans were updated and uploaded into the electronic system in November 2020. Six monthly interRAI reassessments were completed consistently. Some care plan evaluations were not completed following the interRAI reassessments. The overdue interval ranged from 30 days to 60 days. However, the care delivered to the residents met the residents' needs. This was verified by the interviewed staff, residents, and family/whānau.</p>	<p>Five out of the ten care plans reviewed were not evaluated following the six-monthly interRAI reassessments completed.</p>	<p>Provide evidence that care plans are evaluated following six-monthly interRAI reassessments.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	CI	<p>Staff document specific staff/visitor events/incidents on a notification form. This document is scanned into the electronic system and is recorded on the incident management report. Each incident is reviewed and actioned at the time by the BCM, and the clinical manager as needed, especially if it is a clinical incident/event. Once investigated, action plans are developed and implemented and follow up is completed in a timely manner. The resident incidents/events are entered into the electronic system which the organisation is currently transitioning to for incident/accident management. All events, including shortfalls, are used to identify opportunities to improve service delivery and to identify and to manage risk. Staff reported all ‘near miss’ as well as actual events and when interviewed clearly</p>	<p>Having fully attained the criterion the service clearly demonstrates a review and analysis process of incidents and accidents to ensure appropriate corrective action planning has been undertaken to improve the safety and care delivery of residents. The business and care manager was able to print off the incident management report and randomly check cases to ensure they were closed and/or had been reported in a timely manner to HealthCERT if required. The records all required information for each incident that occurred and the reporting by month to the quality management and governance group was evidenced. The adverse event system is closely linked to the quality and risk system and to health and safety for the organisation and is proving to be much more effective with information readily accessible. The electronic system is now superseding the hard copy records. There is evidence of the family being notified when incidents occurred. New strategies in place developed from the outcomes of incident reporting are improving the health outcomes for residents as documented by the business and care manager in much detail. Ongoing evaluation continue to occur</p>

		understood the reasons for reporting the details accurately. An incident management report can be generated at any time to access the progress or to see if each case has been managed appropriately and has been closed out effectively as explained by the business and care manager.	and benchmarking is completed and compared with other services in the organisation.
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>A virtual reality programme was introduced five years ago to cater for residents who do not have regular visits from friends and family due to various reasons including some family living overseas. The project involved recording a video about residents with their consent. This facility was also used to help residents reminisce on long term memories, for example, revisiting their home, favourite park or any other places they would like to visit. For residents who are living with dementia the new virtual reality system is being used as a form of therapy. The virtual reality programme was linked with the “Remember Me” project that grew during the difficult time family were having due to Covid-19 visiting restrictions. The initiative was used to connect residents and families as well as to record memories. With residents and family/whānau consent, residents who wished to participate brought photos, family stories and music they would like to share.</p>	<p>Fourteen residents signed into the Virtual Reality project. Positive outcomes included appreciation from residents and family/whānau who enjoyed the experience and having a medium that can be shared throughout the family/whānau regardless of where they are located. Residents and family/whānau received a USB stick as a gift. This experience has increased staff knowledge about the people they care for and family have learned more and shared with their family. Residents expressed joy in re-telling their stories and memories which even they had forgotten including family emotional connection. The service won an award in the Kalandra community connections award category in the competition held for excellence in care awards 2020 under the New Zealand Aged Care Association and EBOS.</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for</p>	CI	<p>The laundry system processes were changed last year due to the national pandemic. During this time there were a significant number of complaints raised about the laundry process in</p>	<p>Having fully attained the criterion the service clearly demonstrates a review and analysis process of the laundry system occurred to ensure appropriate corrective action planning was undertaken to improve the laundry system at a difficult time and one that has been</p>

<p>cleaning and laundry processes are monitored for effectiveness.</p>		<p>particular around the return of residents' personal clothing being missing or misplaced clothing. Complaint forms were available for review mostly from family and residents. As the laundry and personal clothing was completed off site it was decided to set up a temporary laundry in a cottage located in close proximity to the facility. Permission was granted by support office and the BCM initiated the new process which has been successful with no complaints being received in regard to the personal laundry service.</p>	<p>ongoing. The BCM investigated the complaints, and it was verified that clothing was being misplaced, mixed with other residents' clothes and labels had come off in the wash or that clothes were not named in the first place. The new laundry was set up with permission and a new labelling machine was purchased. All residents' clothes were personally named and with the facility name. Labelling of the clothes improved the situation significantly, but still some clothing went missing occasionally. A trial commenced and some residents' clothing was washed onsite in net laundry bags allocated for individual residents. The new system proved to be very successful, and no clothes have since gone missing and the labels have stayed on. Resident satisfaction has vastly improved in relation to the laundry process and this was evidenced in interviews with the laundry person, residents and family members. Response to this new initiative was also documented in the resident/family survey outcomes and no complaints have been raised about the personal laundry process. Labelling of all clothing is a standard now and this occurs on admission and when residents purchase new clothing items. Now all personal clothing is laundered and managed effectively with net bags (excluding woollens) on site.</p>
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End of the report.