

Oceania Care Company Limited - The Sands

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:	The Sands
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 April 2021 End date: 28 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:	43

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

The Sands Rest Home and Village (The Sands) provides rest home and hospital level care for up to 45 residents. The service is operated by Oceania Healthcare Limited and managed by a business and care manager and a clinical manager. 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, staff and a general practitioner.

The audit has resulted in two continuous improvement ratings related to adverse event reporting and infection prevention and control surveillance. No areas were identified as requiring improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.


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

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

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

A complaints register is maintained with complaints 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. Systems are in place for monitoring the services provided including regular daily, weekly and monthly reporting by the clinical 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 clinical manager at The Sands.

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 newly appointed national quality care and audit manager was present at this audit.

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.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

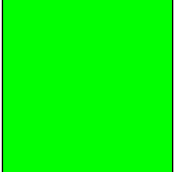
The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely 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. A food control plan is in place. Residents verified satisfaction with meals.

Safe and appropriate environment

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

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. All laundry is undertaken off site. Chemicals used for the cleaning and kitchen services are 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. Five enablers were in use at the time of audit. One restraint was 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	0	50	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Sands rest home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. Caregivers were observed calling residents by their preferred name.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance directives, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are encouraged to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment events in the community.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Even though there were visitors' restrictions recently due to the pandemic, residents and family members interviewed stated they felt comfortable about the way it was managed and were kept well informed.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The 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 seven minor complaints in the last 12 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. There have been no external complaints received in the last 12 months. Oceania support office maintains any health and disability commissioner (HDC) complaints and a register is maintained specifically for HDC complaints. The national quality care and audit manager (QC&AM) present at this audit explained the HDC process and the responsibilities that this role involved including complaints management. The newly employed business and care manager (two weeks into this role) is responsible for complaints management at this facility.</p> <p>The complaints management system has been significantly improved and the business and care manager is currently 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 regional clinical manager. Staff training is provided on complaints management at</p>

		<p>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 and family members 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 in the common areas 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>Residents and families of The Sands rest home confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed to maintain privacy throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and in discussion with families. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</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>One staff member at The Sands rest home at the time of audit identified as Māori. Staff understood Māori cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current organisation wide policy on Māori health plan to guide the facility on the development of their own Māori health plan. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs. Guidance on tikanga best practice is readily available.</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 verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. A cultural assessment is also completed during the admission. The resident satisfaction survey confirmed that individual needs are 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 and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Ongoing education is provided on an annual basis which is confirmed in training records. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</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, wound care specialist, mental health services for older persons, and education of staff. The general practitioner (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.</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 members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, if needed.</p>
<p>Standard 1.2.1: Governance</p>	FA	<p>There is a business plan and quality and management plan for 2021 that is documented for The Sands Rest Home and Village (The Sands). A mission statement, statement of purpose and the philosophy of</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>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 organisation has identified a need to strengthen its oversight and accountabilities of all things clinical, quality and health and safety at a national operational level and a clinical governance group has been developed and implemented. The BCMs and clinical managers and the regional clinical managers are all involved in this new initiative and project. Minutes of meetings were reviewed.</p> <p>The business and care manager (BCM) interviewed has only been in this role for two weeks and is currently being orientated to the role. The regional clinical manager (RCM) has been covering in the interim time and explained the reporting process for the BCM. The RCM normally receives the reports and then reports to the newly appointed national quality care and audit manager (previously the regional quality manager) 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 is an experienced registered nurse who has been in this role for two weeks and has worked in health care in both 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 health care sector including regulatory and reporting requirements. The BCM is aware of the requirement to maintain currency through ongoing management and nursing education as per the individual employment agreement obligations and to meet the requirements for the organisations service agreement with the DHB. The BCM is well supported by the clinical manager and the regional clinical manager. The National QC&AM present at the audit is available to provide support as well. A team of reception and administration staff also provide support to the BCM, residents and families.</p> <p>The service holds contracts with the DHB for rest home level care, hospital level – geriatric care. On the day of audit 43 residents were receiving care; 15 rest home level care and 28 hospital level care.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient</p>	<p>FA</p>	<p>The BCM manages the day-to-day operation of the service. When absent from the facility, there is a clinical manager available to cover and to continue to provide all clinical input. The clinical manager with support of administration team and the regional clinical manager, can manage the business and non-clinical issues.</p> <p>The management team is able to carry out all the required duties under delegated authority. The</p>

<p>and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>national quality care 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>	<p>FA</p>	<p>The BCM and the clinical manager 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. Health and safety meeting minutes were sighted with worker participation.</p> <p>Hazards are identified and documented. A policy and flow chart is available to guide staff. The clinical manager 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.</p>

		<p>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 family/whānau of choice in an open manner.</p>	FA	<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 was one Section 31 notice completed in 2020 to HealthCERT. The BCM and the clinical manager 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 with regards to adverse, unplanned or untoward events occurring and for using the outcomes to improve service delivery and to identify and to manage risk at the facility.</p>
<p>Standard 1.2.7: Human Resource</p>	FA	<p>Policies and procedures reviewed are in line with good employment practice and relevant legislation and</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>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 27 HCAs there are four level one, two level 2, five level 3 and 16 have completed level 4. The administration manager is responsible for the staff records and was interviewed. The clinical manager is also interRAI trained. Four of ten (10) registered nurses (RNs) are fully trained and competent with interRAI assessments and two RNs were in training at the time of the audit.</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 are 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</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</p>

<p>providers.</p>		<p>covering the service areas. Continuity of service delivery is promoted and teamwork is encouraged. All registered nurses are experienced in aged care and there are no new graduate nurses employed currently.</p> <p>An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. No bureau staff have been utilised for the last nine months except occasionally for the food service.</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. The roster covers the staffing for the two wings the BCM and CM working Monday to Friday covering the total service. ON the morning shift there are two registered nurses and eight health care assistants (HCAs) with four HCAs covering each wing. Team work is encouraged. On the afternoon shift there are two registered nurses and six HCAs and night duty one registered nurse and three HCAs.</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 resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographics, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. All resident clinical records are maintained on online patient and medication management systems. All staff has individual login/access to this information.</p> <p>Archived records are held securely on site and are readily retrievable. All hard copy documents are scanned and uploaded onto the online systems.</p> <p>Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service or registered nurses. 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.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic</p>

services has been identified.		detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. Family of the resident reported being kept well informed during the transfer of their relative.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Regular medication audits are completed and are followed with appropriate corrective actions. There is evidence of pharmacy involvement.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There are four residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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 the executive chef and food service assistants and a café assistant. The food service is in line with recognised nutritional guidelines for older people. There are two qualified chefs and four assistants. 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 and next expires 28 March 2022 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 executive chef interviewed reported that no food is reheated. Fridge and freezer temperatures were recorded. Food is delivered from the kitchen to the first floor in heat boxes. Kitchen assistants and staff serve the meals in the main dining room.</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>The regional clinical manager reported that feedback on the food services is sought from residents and families 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>	<p>FA</p>	<p>The care suites are purchased by the individual residents. Those resident's requiring rest home of hospital level care are assessed by the local needs assessment service coordinator (NASC) if required for care to be provided. The NASC advises if the services are not suitable to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident changes and they are no longer suitable for the service offered, a referral for reassessment to the NASC would be made by the clinical manager/GP. All residents have an access agreement which is a legal document.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents are assessed to develop initial care plan. Within three weeks of admission a comprehensive assessment is completed using nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, depression scale and interRAI as a means to identify any deficits and to inform long term care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of four trained interRAI assessors on site.</p> <p>Files reviewed had evidence of wound management such as wound care plan, evaluation. Evidence of wound management including photographs of chronic wounds was sighted. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</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 families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level 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,</p>	<p>FA</p>	<p>The activities programme is provided by one trained diversional therapists (DT) holding the national Certificate in Diversional Therapy (Level 4 February 2021), and two activities coordinators. The diversional therapist has worked for the organisation for 10 years but at this facility for one year. The activities programme is provided every day of the week including weekends with two staff Monday to Friday. One staff member and with assistance of the care staff in the weekend. The activities are held in the large activities lounge and one on one is provided to residents as needed. Van outings are provided</p>

<p>age, culture, and the setting of the service.</p>		<p>twice a week. Staff involved have completed loading competencies.</p> <p>A social assessment and history assessment is completed on admission by the DT 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, exercises and other interesting topics. The hairdresser is available on an appointment system and a hairdressing salon is situated on the ground floor of the facility.</p> <p>Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings held three monthly 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.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. The Sands rest home has contracted GP who visits twice weekly. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. All referrals are followed up by the GP. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. 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>provided to meet consumer choice/needs.</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 since May 2019 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 purpose.</p>	<p>FA</p>	<p>A building warrant of fitness which expires 2 October 2021 is publicly displayed at reception. 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 was completed 27 January 2021 and calibration of bio-medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The facility is a purpose built facility and all furniture, furnishings, equipment and resources are all new.</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 knew 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 by the maintenance manager. Samples are measured from the tap and</p>

		the hot water temperature cylinder readings obtained. If any variances from requirements occur the preferred contracted plumber is contacted. The preferred provider contact list was updated August 2020.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All 44 care suites are either studio or one bedroom suites. There is a hand basin (vanity unit), toilet and shower in all individual rooms. There are adequate numbers of accessible bathrooms and toilets throughout the facility including visitors and staff toilets.</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. The service has 11 lunar hoists (ceiling hoists), one full hoist and two standing hoists which meet all requirements and have been checked for 2021.</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 is one large shared room occupied by a couple. 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 rooms are care suites and residents interviewed were able to choose their own room being a new facility.</p> <p>A variety of beds were sighted (eg, high low and hospital beds). 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</p>	FA	<p>There are communal areas available for residents to engage in activities. There are two large lounges and one smaller lounge and one large dining room available. Lounge and dining areas are spacious and enable easy access for residents and staff. A large screen television is available in a separate lounge available for the activities programme and comfortable seating is provided. Residents are able to access areas for privacy. There is a large courtyard downstairs in the front of the facility and an outside courtyard at the rear of the dining room with table and chairs. Shade in the form of umbrellas is</p>

<p>their relaxation, activity, and dining needs.</p>		<p>available. Raised gardens are located in this area.</p> <p>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 lounge. A homely atmosphere is developed throughout the facility with extensive outlooks and views of the harbour and grounds.</p> <p>The grounds at the front of the facility are located on the ground floor can be utilised and 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 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. Pick up is six days a week at 8.30am. The staff are responsible for putting away all linen and residents' personal clothing when returned from the contracted linen service provider. All personal clothing is labelled and chipped when residents' are admitted to this service. Trolleys are used for this purpose and this system is working effectively. The laundry person covers the service seven days a week. Residents/families interviewed reported that laundry is well managed and their clothes are returned in a timely manner. The laundry room sighted is set up to meet the needs of the residents. A laundry chute is available as the care suites are located on the first floor.</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.</p> <p>There are three cleaners rostered on duty seven days a week. 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 education records reviewed.</p> <p>Material data sheets are available and accessible as needed. The service is maintained to a high standard. The executive chef interviewed is responsible for the ordering of all chemicals for this facility. Products are monitored for effectiveness by the contracted chemical/products service provider. Internal audits occur for the cleaning and laundry services as per the audit schedule reviewed.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</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 4 June 2021 and remains</p>

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>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 22 April 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. A sensor monitored entrance to the lift from visitor car park is available.</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 45 maximum residents for a minimum of three days. Emergency lighting is available. A water tank of 2000 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 designated cupboard being available with all emergency resources needed in an emergency including a bank of batteries. 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 monthly 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 organised and has a preferred provider list to contact appropriate personal as needed and in a timely manner.</p> <p>Staff for the village ensure the facility is locked at a pre-determined time each evening. 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 an environment that is maintained at a safe 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 resident's individual care suites, 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>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The Sands 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 January 2021.</p> <p>The clinical manager supports 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 clinical 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>	FA	<p>The ICC has appropriate skills, knowledge, and qualifications for the role and currently oversees the programme. The ICC has attended relevant study days provided by Oceania, as verified in training records sighted. In addition to this the clinical manager is completing external infection control study in relation to microbiology and epidemiology for professional development. An experienced registered nurse is currently training to take over this role. 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. The infection control committee meet regularly and are staff from different areas of the facility for example a kitchen representative, maintenance, activities coordinator, guest services manager and care staff.</p> <p>There is a designated pandemic resource cupboard with outbreak stock and general use personal protective equipment. Adequate resources to support the programme were evident. There have been no outbreaks of infection since the previous audit.</p>
Standard 3.3: Policies and	FA	The infection prevention and control policies reflect the requirements of the infection prevention and

<p>procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>control standard and current accepted good practice. Policies were last reviewed in January 2021 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 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</p> <p>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</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, 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. Infection control logs are maintained for each individual resident. 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 regional clinical manager and the support office. Data is benchmarked externally with other aged care providers within Oceania. 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 as per the schedule reviewed. A continuous improvement rating was acknowledged for the project developed and implemented to reduce the rate of urinary tract infections and prevention outcomes.</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 restraint co-ordinator is a registered nurse and has been in this role since September 2019. A job description for this role and responsibilities is clearly outlined and was updated January 2021.</p> <p>On the day of the audit one resident was using restraint. Five 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 registered nurse (restraint coordinator), the GP/NP and the individual resident/EPOA 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</p>

		records of the one resident who was using a restraint in the form of a bedrail.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	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. 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 is current and up-to-date. The restraint coordinator is responsible for maintaining 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>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of the resident's individual record showed that the individual use of restraint is reviewed two monthly and documented in the progress records. In addition to this restraint reviews occur and are fully evaluated during the care plan and interRAI assessment undertaken six monthly. The restraint evaluation is also completed by the restraint approval group. Family interviewed confirmed their involvement and satisfaction with the restraint process. The evaluation covers all requirements 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.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint reviews are completed six monthly of all restraint use which includes all the requirements 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, 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</p>

		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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	CI	<p>All unplanned or untoward events including any shortfalls in order to identify opportunities to improve service delivery and to identify and manage risk are clearly documented. A system is developed and implemented.</p> <p>Incident/adverse events were reviewed. Staff reported all near miss as well as actual events and when interviewed clearly understood the reasons for reporting the details accurately. Follow-up is completed in partnership with the health and safety team and the staff involved. The clinical manager ensures all incident forms are reviewed and signed off. Identification of an opportunity for improvement through incident reporting analysis, internal audit occurred when several frequent fallers were identified at this facility. The monthly falls audit evidenced this was the case. Strategies were put in place with use of sensor mats, consistent handovers, half hourly checks and family conferences were held as part of the multidisciplinary review process. Personalised care plans were developed for each resident involved for example implementing hip protectors, chair raises and physio sessions. Constant reviewing of staffing, skill mix and ratio proved to be efficient. Sensor mats did not prove to be the most effective in preventing falls due to technical problems and compliance issues. Re-evaluation evidenced that this</p>	<p>Having fully attained the criterion the service clearly demonstrates a review and analysis process of all incidents and accidents especially in this case for residents' falls to ensure appropriate corrective action planning has been undertaken to improve the safety and care delivery of residents. With all residents involved in this project the action plans were discussed for effectiveness and what had been achieved. The clinical manager found that consistent handovers were very effective with all staff being involved this in turn resulted in the significant reduction in the falls rate. The interventions put in place by the team to manage falls has had a tremendous</p>

		significant improvement boosted staff morale, thereby affirming the measures implemented. Residents reported they felt increased safety and are content with these measures in place.	impact in curbing the number of falls from November 2020 to March 2021 by 50%. Half hourly rounding for high falls risk residents proved to be the most effective measure in preventing falls. The personalised care plans with individual management strategies were effective and worked efficiently.
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>When evaluating the trends of urinary tract infections (UTIs) it was observed that they were increasing from January to May 2020. The clinical manager and the infection control coordinator worked on this to identify the causes and work on the strategies to address this issue. An analysis report was reviewed. The sudden increase of UTIs was attributed to the lock down for Covid 19 that the staff and residents were dealing with. April had been a testing period which posed medical and mental health issues for the clinical team to deal with. The changes in behaviour of some residents was the gold standard for the nursing team to rule out UTI. Though the samples were sent to the laboratory, towards the second week in April these were not being processed in a timely manner. The residents were managed with non-prescription interventions as the GP would want to wait for the definitive sensitively results from the laboratory. Those residents reviewed in May had already commenced onto oral antibiotics. This experience led the clinical manager and ICN to review staff practices. Residents' fluid intake and RN understanding of guidelines in place increased. Based on the information collated a strategic plan was implemented in the month of June onwards. ICC monitoring and evaluating staff members' infection control practices was implemented. Strict maintenance and assessment of fluid balance charts were instigated to ensure adequate intake occurred for all residents. RNs were fully instructed on the IC policy and this clearly stated the requisite of three criteria that determines a UTI. Ongoing evaluations evidenced only one resident requiring long term antibiotics for a chronic UTI. A follow-up was arranged for the resident at the urology clinic at the DHB.</p>	<p>Having fully attained the criterion the service clearly demonstrates a review and analysis process of infection reduction and prevention outcomes to benefit the residents in a safe and timely manner. Full documentation was provided to evidence this CI process. Infection control meeting minutes were accessible and were reviewed. The clinical indicator graphs reviewed indicated a significant decrease in the number of reported UTIs by approximately 75% at this facility and strategies implemented remain in place as a preventative measure. Staff education sessions were increased with updates regarding good practices, hygiene, perineal care, incontinence management and hydration with full attendances by staff have been observed and continually evaluated.</p>

End of the report.