

# Oceania Care Company Limited - Elmwood Rest Home and Village

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## Introduction

This report records the results of a Surveillance 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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Elmwood Rest Home and Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 1 July 2021      End date: 1 July 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	149

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Elmwood Rest Home and Village provides residential care for up to 160 residents who require hospital, rest home and physical or intellectual disability level of care.

The service is operated by Oceania Healthcare Limited. Day to day management and all service delivery is overseen by a business and care manager (BCM) who is a registered nurse (RN). The BCM is supported by an RN clinical manager (CM) who manages the overall delivery of clinical care. The CM returned from holiday leave to assist with the audit. This person supervises two clinical nurse leads who work on the floor. Both the BCM and CM are suitably qualified and experienced as managers in aged care. They are directly supported by two Oceania executive leaders, the regional clinical quality manager and regional operations manager. The regional operations manager attended for part of the audit.

There have been no changes to the size or scope of the services provided since the previous certification audit in 2019.

This surveillance 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 files, observations and interviews with residents, family members, management, staff, a visiting gerontology nurse specialist from the district health board (DHB) and the nurse practitioner.

Feedback from all interviewees was positive.

There were no areas identified as requiring improvement as a result of the audit. Two ratings of continuous improvement were awarded for achievements in reducing infections and pressure injuries.

The two improvements required from the 2019 audit, had been closed out by the DHB. Onsite reassessment of these confirmed that the actions taken were effective and the issues no longer exist.

## 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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Open communication between staff, residents and families is promoted, and confirmed to be effective. The resident and staff population is multicultural and there are practical processes in place which enable communication with residents and family who speak other languages. There is also access to external interpreting services if required.

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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Service monitoring is regular and reliably reported to the governing body. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The multidisciplinary team, including a registered nurse and general practitioner or nurse 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. 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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There is a current building warrant of fitness. There have been no changes to the physical layout of the facility since the previous audit.

## 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. Three enablers and five restraints were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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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.

## 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	15	0	0	0	0	0
Criteria	2	38	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 1.1.13: 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 requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The BCM is responsible for managing complaints. The complaints register reviewed showed that four complaints had been received and effectively managed since the previous audit in 2019. A sample of complaints reviewed confirmed these were investigated promptly and that the matters were resolved within suitable timeframes, with all parties being kept informed about the process. Where possible, actions had been implemented to improve and address service shortfalls.</p> <p>Interviews confirmed that the complaints process was explained to residents and family on admission. Complaint forms were available at the entrance to the facility. Residents and family interviews confirmed that they were aware of the complaints process and felt comfortable in making a complaint should they need to do so. They stated that any issues raised had been dealt with effectively and efficiently. Residents demonstrated an understanding of their rights and how to access advocacy services if they required support during a complaints process.</p> <p>There have been no known complaints submitted to the Office of the Health and Disability Commissioner (HDC) or other external authorities since the previous audit.</p>
<p>Standard 1.1.9: 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</p>



<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>reviews. This was supported in residents' records reviewed.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. All incident and complaint documentation, residents' records and family interviews confirmed that open disclosure is practiced as required.</p> <p>Communication across all levels of staff, between staff and residents and their families, the community and external health services was consistently described as excellent by all interviewees. The relationship between the funder (Counties Manukau DHB) and the facility's reputation for quality care of older people has been greatly enhanced by the current operators according to the external providers interviewed.</p> <p>Regular resident meetings and facility newsletters keep residents and their families fully informed about 'goings on', future and past activities. Resident and family interviews confirmed that the communication needs of all residents, including younger people with disabilities (YPD), were effective and appropriate. The demographics of the area give rise to a very multicultural resident and staff population. Key staff use translation 'apps' on their cell phones which enable immediate communication with residents and their family members who are not fluent with the English language. Staff from other cultures often provide onsite interpretation and families also assist. The BCM and activities staff reported that external interpreter services are seldom required.</p> <p>Written information is available and sourced in alternative formats to suit the needs of specific residents when necessary. Two of the YPD residents had been supported to procure funds for activities and communication devices that greatly enhanced their connection with their communities and the outside world.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Oceania Group and their executive management team are responsible for the service provided at Elmwood. Oceania has a documented mission statement, vision and values which includes a philosophy of resident centred care. These are available to residents and their families on the company website, are provided with the enquiry pack and are available at the facility. Elmwood's admissions officer provides a smooth and comprehensive admission process which includes ensuring that all parties are fully informed and understand what to expect from the organisation. This person was described as a valuable resource who is highly regarded by the families interviewed. The staff orientation programme includes an introduction to and training on the group mission, vision and values.</p> <p>Elmwood has a facility specific business plan for 2021 – 2022 which responds to the group's annual business plan and includes time framed and well described objectives for the year. This is presented in an easy-to-understand format for new staff from other cultures. Each of the plans sighted reflected a person/family centred approach. This was especially apparent at Elmwood where the atmosphere, building layout and design, staff philosophy and culture is resident centric and directed to all people including those with physical and intellectual disabilities.</p> <p>The facility is managed by a BCM who is supported by an onsite full time clinical manager (CM). The BCM was appointed to the role over three years ago and has established excellent working relationships in the locality according to testimonies from various interviewees. This person has extensive experience in managing residential</p>

		<p>health services including aged care and mental health facilities and is maintaining professional competencies and a practising certificate as a registered nurse (RN) with a postgraduate diploma in mental health.</p> <p>The CM is also maintaining professional competencies and a practising certificate as an RN. This person previously worked as a CM with the BCM at another aged care facility and took up the role at Elmwood shortly after the BCM. The CM is supported by two experienced RNs who are designated clinical nurse leaders (CL) who are on the floor to oversee RN and HCA workloads each day. All of these leaders are provided with professional guidance and support as and when required by the Oceania executive team of national and regional managers.</p> <p>Regular communication between Elmwood leaders and Oceania executive management occurs. For example, fortnightly forums for all Oceania BCMs, and separate fortnightly forum for CMs within similar localities. The regional operations manager attended for part of the audit to provide support and the regional clinical/quality manager joined the closing meeting by telephone. Extensive monthly management reports provide Oceania executive leaders with information progress against identified indicators. In addition, there is two weekly monitoring of the clinical indicators by the BCM and the Oceania clinical quality manager.</p> <p>Elmwood is certified to provide respite, and long term medical and geriatric hospital level care, rest home level care and physical /intellectual disabilities residential care for up to a maximum of 160 residents. There is an aged related residential care contract (ARCC) with Counties Manukau DHB and agreements to provide Long Term Support-Chronic health Care (LTS-CHC) respite/short stay and care for people after their public hospital admissions (POAC). The service also has contracts with the Ministry of Health to provide residential non-aged care services for people under 65 years of age (YPD) and those with physical and/or intellectual disabilities (PD/ID)</p> <p>On the day of audit there were 153 beds occupied but only 149 people receiving care. The other four people were occupying care suites but not requiring staff interventions apart from meal and housekeeping services. Of the 149 people, 80 residents were assessed as hospital level care. Five of these were under the age of 65 years (YPD) and one resident was receiving care under the long term support –chronic health conditions. There were 69 rest home residents. Of these, one hospital resident and one rest home resident were off site in the public hospital.</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</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. Policies and procedures are reviewed regularly at the senior leadership level to ensure they continue to meet best/safe practice. Staff confirmed that when changes to policy or practice occur, they are informed and educated about the changes. All previous versions of the policies are removed/marked as obsolete and replaced with the current version.</p> <p>The quality system includes management of incidents/accidents and complaints, infections, restraint, internal audits, regular resident and family satisfaction surveys and ensuring that any remedial actions required from audits and consumer feedback is implemented to good effect.</p> <p>The clinical team had been regularly submitting quality initiative projects to the GM of nursing. Two of these were</p>

<p>system that reflects continuous quality improvement principles.</p>	<p>identified during this audit as warranting ratings of continuous improvement because they clearly fulfilled the requirements. These are described in part three continuum of service delivery for reduction and prevention of pressure injuries and in the infection prevention and control standard for a project that reduced the prevalence of respiratory infections amongst residents.</p> <p>Meeting minutes and interviews confirmed regular review and analysis of quality data/indicators and showed that related information is reported and discussed at a range of staff meetings, and/or communicated via time target, and on group chat for expediency. The Elwood meeting planner showed monthly meetings for CMs, health and safety committee, quality and staff meetings, RNs, infection control committee, weights team, pressure care team, falls prevention team, the palliative care committee and bimonthly meetings for residents, the restraint team, activities, housekeeping and kitchen staff.</p> <p>Staff reported their involvement in quality and risk management activities through participating in house committees, taking up specific projects of interest, conducting audits or offering general solutions and ideas during group meetings. As above, there was written evidence that relevant corrective actions are developed and implemented to address any shortfalls. Feedback from resident and their family is gathered at regular intervals each year. These may be general satisfaction surveys or for specific purposes for example, food/meal/menu surveys or activities evaluations. The service is finding that conducting one large annual survey does not yield a high return rate, so are trying different methods to increase participation and achieve results that can be measured. For example, sitting with residents to support them to complete a survey, or focusing on specific service areas or using electronic 'survey monkey' for family surveys. Staff satisfaction is measured by "survey monkey each year. Results of recent surveys from younger residents provided valuable feedback that resulted in initiatives to better suit them (see evidence in 1.1.9). Residents' meetings provide an excellent forum for gathering feedback that drives service improvements. All resident and family members' interviewed confirmed that the service regularly and actively seeks their feedback and uses this to make changes.</p> <p>Younger residents with a physical disability expressed satisfaction with regards to making decisions. Younger residents live throughout the facility rather than being all together in one area and they reported this was their choice. Younger residents have electronic equipment and all necessary aids to help mobility and independence.</p> <p>Oceania has a risk management programme implemented which documents how risks are managed in clinical services, the environment, with human resources and other areas at this facility. Health and safety policies and procedures are documented along with a hazard management programme. The hazard register sighted was current and is kept updated.</p> <p>Staff interviews confirmed an awareness of health and safety processes and the need to report hazards, accidents and incidents promptly.</p> <p>The BCM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and understands the requirements. There have been no WorkSafe notifications since the previous audit.</p>
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<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these contained all expected information, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the support office. Corrective actions arising from incidents/accidents were implemented. Information gathered is shared with staff at their meetings with incidents/accidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Specific learnings and results from incidents/accidents inform quality improvement processes which are planned amongst teams, implemented and reviewed at regular intervals. Outcomes from these are shared across all staff and the wider Oceania group (as evidenced in Standard 1.2.3)</p> <p>Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on an incident/accident form which is signed off by the BCM. Incident/accident reports selected for review evidenced the resident's family had been notified, an assessment had been conducted and observation completed. There is evidence of a corresponding note in the resident's progress notes and notification of the resident's nominated next of kin where appropriate.</p> <p>Interviews with the BCM and CM showed they clearly understood essential notification reporting requirements. They advised there have been four notifications of significant events made to the Ministry of Health, and DHB since the previous audit. These included a stage 4 pressure injury in July 2020 and another in February 2021 (neither were facility acquired), a resident aspiration in July 2021, and a resident who tested positive for tuberculosis in November 2020.</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>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and then annually.</p> <p>Elmwood follows the Oceania approach to professional development which ensures that ongoing education is provided to all staff. Training records and interviews confirmed that all staff had undertaken a minimum of eight hours of training relevant to their roles. Continuing education is planned and coordinated nationally each year. This includes role specific mandatory annual education and training modules that are provided via study days (GEM). Each facility also has the ability to implement other upskilling opportunities, such as using 'tool box tutorials' and inviting in guest presenters for specific purposes.</p>

		<p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Of the 96 HCAs and activities staff currently employed, 44 have completed Careerforce training to level 4, 21 are at level 3, four are at level 2 and 27 are either preparing or have commenced level 1. The diversional therapist is identified as the internal assessor for the programme. The HCAs on regular night shifts have current medication competencies and first aid.</p> <p>Cleaning staff have cleaning qualifications and all kitchen staff have completed unit standards on food safety.</p> <p>Of the 25 RNs employed, 17 plus the CM and two clinical nurse leaders have completed interRAI assessments training and competencies.</p> <p>Education session attendance records evidenced that ongoing education is provided relevant to the services delivered. The recently introduced electronic training register (LMS) readily identifies individual care staff who are due to complete their required training and competencies, for example, fire training, infection control, hoist use, restraint minimisation, medication management, and wound management.</p> <p>Each of the staff records sampled contained evidence that training and annual performance appraisals were up to date.</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 and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7).</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. The BCM and CM are on call after hours seven days per week and staff reported that access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least two staff members on duty had a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage.</p> <p>There are set rosters for each of the four areas in the facility. One area is utilised as 'dual purpose', one is utilised for hospital level care residents, one for rest home residents and one includes 25 care suites, which includes the 21 apartment care suites. The rest home area adjoins the care suite area to enable staff to move freely among all residents' rooms.</p> <p>Residents, including those in the dual purpose wing at hospital level, have their needs met by sufficient staffing levels. Rosters are confirmed for staff one month in advance and staffing levels are reviewed to accommodate anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. There are sufficient RNs and health care assistants (HCA) available to safely maintain the rosters for the provision of care, to accommodate increases in workloads and acuity of residents. The</p>

		<p>four separate areas each have a nurses' station.</p> <p>The CM is on duty on the morning shift Monday to Friday and there is at least one CL on the morning shift, seven day per week. The CLs are each responsible for two facility areas. In addition to the CM and CLs, there are six RNs and at least one enrolled nurse (EN) on the morning shift, five RNs on the afternoon shift and two on night shift. There are 19 HCAs on morning, 17 on afternoon shift and seven on night shift, seven days per week. Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract. There are sufficient RNs and HCAs in each area to ensure that all hospital level residents including those in dual purpose rooms and care suites, receive the appropriate level of care and oversight which meets the requirements of the ARRC agreement.</p> <p>The services for residents with ORA are the same as services for rest home and hospital services for residents under the ARRC contract and other contracts at the facility.</p> <p>The facility will from time to time provide support to residents residing in the retirement village for medical issues. Interviews and roster reviews confirmed that there are sufficient staff remaining in the facility for the short-term absence of an RN attending to village residents.</p> <p>There are 151 staff, including: the management team; administration; clinical staff; diversional therapist; activities staff; and household staff. Household staff include cleaners who provide services seven day a week, a laundry assistant and kitchen staff.</p> <p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Resident and family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed that whilst they are busy at times, they complete their scheduled tasks and resident cares over rostered shifts.</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.</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 as confirmed by staff records.</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. Clinical pharmacist input is provided on request.</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</p>

		<p>entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP/NP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There was a resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. The resident interviewed demonstrated how the medicines were securely stored in their room and could articulate what medicine was taken, when, and for what purpose.</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>	FA	<p>The food service is provided on site by qualified chef and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (20 March 2021). The menu follows summer and winter rotations and a four week cycle.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Ministry for Primary Industry and is current until 28 March 2022. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have completed appropriate certificates and participate in annual reviews.</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. An allergy alert board is available near the servery and storage points. Special equipment, to meet resident's nutritional needs, is available. Coffee machines are available for residents to make hot drinks for family/friends.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. After a seasonal menu change the executive chef makes a point of visiting residents and getting their feedback. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service</p>	FA	<p>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 resident's individualised needs was evident</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a 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 levels of care provided and in accordance with the residents' needs.</p> <p>At the last audit a corrective action was raised in response to care of pressure injury management. The staff have put a programme in place which has seen a dramatic improvement in identifying and managing pressure injuries that is worthy of a continuous improvement rating.</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>FA</p>	<p>The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy, and three assistants enabling the programme to be run over seven days. Residents were observed engaging in exercise classes on the day of audit. A large display board has photos and event reminders in the hallway by the activities room. Photo consent is obtained as part of the general consent form on admission. Family members are able to obtain photos if desired.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated on engagement and as part of the formal six monthly care plan review. Progress notes are documented monthly for each resident. For the residents under 65 years there are age appropriate activities and outings.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme fun and stimulating.</p>
<p>Standard 1.3.8: Evaluation</p> <p>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 for wounds, weight loss and infections. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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 current building warrant of fitness (expiry date 16 March 2022) is publicly displayed. There have been no changes to the physical structure of the building since the previous audit.</p> <p>The previous non-conformance related to the surface heat from panel heaters has been mitigated. Initially by carrying out daily checks of the heater temperatures to ensure these do not exceed 45 degrees or known skin burning temperature and eventually by installing a cover over each heater to prevent skin contact.</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>CI</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager/quality, IPC committee and regional quality manager. Data is benchmarked externally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>An initiative of the IPC coordinator has seen a reduction in infections, especially respiratory infections, and is worthy of a rating of continuous improvement.</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 the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice their responsibilities.</p> <p>On the day of audit, five residents were using bedrails and lap belts as restraints and three residents were using enablers (two bed rails and one lap belt), which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff. The service is actively working to prevent and minimise the use of restraint.</p>

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## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	CI	In 2018/19 there were 25 pressure injuries. A programme was introduced to raise awareness of the prevention and management of pressure injuries (PI). Education was increased and a multitude of sources were utilised. This included online training, study days, visiting speakers from a medical supply company, posters, displays and discussions at staff meetings. New staff employed had to complete an online education series on prevention of PIs during orientation.	Increased education from both internal and external services has empowered staff to improve the management of highly dependent residents and has resulted in a 52% reduction in pressure injuries.
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in</p>	CI	Routine surveillance was demonstrating a high infection rate, so the IPC coordinator set out to educate staff and particularly residents about infections. A bimonthly newsletter was developed highlighting a 'Bug of the Month', with information on how to decrease the spread of the 'bug', as well as with a corresponding quiz to reinforce the information. Residents took the information	There has been a reduction in infections since 2018, especially those effecting the respiratory system, by

<p>achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>and applied it by doing such things as drinking more, hand hygiene and remaining in their rooms if unwell. The newsletter was discussed at staff and quality meetings and staff encouraged residents to read the information.</p>	<p>as much as 79% due to the residents and staff being educated in infection control matters.</p>
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End of the report.