# Oceania Care Company Limited - Holmwood

## 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 Health Audit (NZ) 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Holmwood Hospital and Rest Home

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 11 November 2014 End date: 11 November 2014

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 50

# 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** |
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|  | 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 |
|  | 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

This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standards and the District Health Board contract. The facility is operated by Oceania Care Company Limited.

Holmwood hospital and rest home provides care for up to 57 residents. On the day of this unannounced surveillance audit there were 50 residents residing at the facility.

The area identified as requiring improvement at the last certification audit that related to recording and implementation of corrective actions following complaints is met, however this surveillance audit identified an improvement required around recording and implementation of corrective action plans following internal audits and satisfaction surveys.

The area identified as requiring improvement at the last certification audit that related to adhering to timeframes of resident assessments is met, however this surveillance audit identified an improvement required around recording of residents’ neurological assessments following adverse events.

The area identified as requiring improvement at the last certification audit that related to residents’ care plan interventions is met.

There is an area identified as requiring improvement at this surveillance audit around not for resuscitation orders.

## Consumer rights

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| 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

An open disclosure policy is documented and implemented. Interpreter services are available, if required. The complaints process is made known to residents and families on admission and displayed in the facility. Staff, residents and family interviewed demonstrated an understanding of the complaints process. A complaints register is maintained and up to date.

There is one area identified as requiring improvement around not for resuscitation orders.

## Organisational management

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |

Oceania Care Company, the governing body has systems in place which define the scope, direction and goals of the organisation and the facility. There are monitoring and reporting processes against these systems. The quality improvement data is reported to the governing body on a monthly basis. Internal audits are conducted. There is an area identified as requiring improvement around recording and implementation of corrective action plans following internal audits and satisfaction surveys.

The facility was managed by the Oceania clinical and quality manager, registered nurse, since the business and care manager left the facility in October 2014. Interim business and care manager for Oceania, registered nurse, commenced employment at the facility on the day of this surveillance audit. There is a clinical manager, a registered nurse who oversees the clinical services at the facility.

The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is evidence in the residents’ files reviewed of reporting of adverse events. The residents files reviewed also provide evidence of communication with families following adverse events or change in resident’s condition.

The risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual and clinical risk. The human resource management system provides for the implementation of staff orientation and in-service education and training. There are regular in-service education and training opportunities provided for staff. The review of staff records provided evidence of human resources processes being followed and individual education records were maintained.

There is a documented rationale for determining staff levels and staff skill mixes. All staff interviewed report there is adequate staff available.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The residents receive services from suitably qualified and experienced staff. The care plan evaluations are documented, resident-focused and indicate the degree of response to the intervention and progress towards meeting the desired outcomes. Where the progress of a resident was different from what was expected, the service responded by initiating changes to the person centred care plan. The family have the opportunity to contribute to the person centred care plans.

The reviewed files evidenced short term care plans for acute conditions and person centred long term care plans for service delivery. Resident, nursing and medical reviews were conducted within the required timeframes.

The activities were planned and the programme was displayed providing access to residents and family. The activities reflected the skills, strengths and the interests of the residents. Each resident file had an activities plan, attendance record and a completed diversional therapy evaluation sheet. Activity goals included physical, intellectual, cultural and spiritual needs of residents.

The medicine management system provided safe and appropriate prescribing, dispensing, review, storage, disposal and reconciliation. Medicine management training was conducted annually. The medicines policy included a section on the self-administration of medicines. There were no residents self-administering medicines on day of the audit. Service providers responsible for medicines management completed annual competencies. The medicines round in the hospital was observed at lunch time. Medicine fridge temperatures were maintained and recorded.

The food and nutritional needs of residents were provided in line with recognised nutritional guidelines that were appropriate to the needs of the residents. Menus were reviewed annually. The cook received a duplicate of the dietary plan for new residents in order to ensure dietary needs of the residents are implemented. Food procurement, production, preparation, storage, transportation, delivery and disposal complied with legislation and guidelines. Kitchen staff completed food safety training.

There is an area identified as requiring improvement relating to service provision requirements ensuring the residents assessed needs to be consistently documented following adverse events.

## Safe and appropriate environment

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

The management advises there have not been any alterations to the building since the last audit. A building warrant of fitness is current. Review of documentation, visual observation and interviews with residents, family and staff provided evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose.

## Restraint minimisation and safe practice

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| 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. |

Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrated residents were experiencing services that are least restrictive. Systems were in place to ensure assessment of residents is undertaken prior to enabler or restraint usage being implemented. The resident's files reviewed demonstrated enabler and restraint assessments, risk assessments and monitoring processes were implemented and followed. Enablers and restraints were recorded in the restraint register.

## Infection prevention and control

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| 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. |

Surveillance was appropriate to the size and complexity of the organisation.

Review of documentation provided evidence that the service had a surveillance reporting process in place. Surveillance results were reported on an 'Infection Log' in each area of service. The clinical manager collated this information at monthly intervals and the data was recorded as clinical quality indicators on the Oceania intranet. Clinical quality indicators were reported at the health and safety, quality, registered nurses and staff meetings. This data was expressed in graphs, included in reports and displayed in clinical areas. Staff interviews reported surveillance information being available for them to read.

Infection control education was provided annually as part of the in-service education programme. Staff members completed annual infection control competency testing, including hand washing competencies.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 15 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 43 | 0 | 1 | 2 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Moderate | The policy and procedures document the organisation’s requirements regarding informed consent. Staff members undergo annual education and demonstrated understanding of the support required by residents and/ or their family to be actively involved in the consent process. General written consent is required from all residents for retention of health information, treatment, outings and use of the photographs of residents. This was confirmed during the clinical manager, RN and health care assistants interviews, however there is an area requiring improvement around not for resuscitation orders. Policy regarding advanced directives are in place.  The admission process includes ascertaining the resident and or family’s understanding of informed consent. Families may assist with interpretation if required and interpreter services are available. Information regarding care is given to residents and interventions are discussed.  The relevant District Health Board contract requirements are not fully met. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The Oceania Care Company wide complaints policy and procedure are congruent with Right 10 of the Code of Rights (last reviewed July 2014).  There is a complaints register, which is current and monitored by management. The complaints register for 2014 is reviewed and records five complaints. There is evidence of records of the date the complaint was received, the date the written acknowledgement was sent, corrective action as a result of the complaint, date the investigation was completed and if the complaint was resolved to the satisfaction of the complainant.  The complaints process documentation is included in the facility welcome and information pack and located at entrance to the facility.  The residents and family members interviewed were aware of the complaints processes. Health and Disability Commissioner (HDC) brochures on Code of Rights and Learning from Complaints are displayed throughout the facility. The Nationwide Advocacy Service and the HDC contact details are also available at the facility.  The management stated there has not been any complaints since the last certification audit, referred to the Health and Disability Commission, police, coroner, Accident Corporation or Ministry of Health.  The area requiring improvement identified at the last certification audit around recording and implementing of corrective action plans following complaints is met, however corrective action plans following audits and satisfaction surveys require an improvement (refer to 1.2.3.8.)  The relevant District Health Board contract requirements are met. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There are policies and procedures in place to support the open disclosure practice in the facility. Incident forms, residents’ progress notes and family communication forms evidence family are informed of adverse events or when resident’s condition alters, confirmed at clinical staff interviews.  Residents and family members interviewed confirm that staff and management communicate well with them.  The registered nurse (RN) advises there are no residents requiring interpreter services at time of audit.  Admission agreement was sighted and contains all required information including full details of resident’s rights to receive or not receive additional services and charges for additional services. Service information in the form of an information pack is available and appropriate to the communication needs and capabilities of the residents, families and referring agencies.  The relevant District Health Board contract requirements are met. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Oceania Care Company Limited has systems in place that record the scope, direction and goals of the organisation and the facility. Monthly reports to the governing body are provided by management via the Oceania intranet and include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes and clinical indicators, sighted. The Oceania values, mission statement and philosophy are displayed at the entrance to the facility. The philosophy is in a form that is easily understood.  The interim business and care manager is a registered nurse (RN) with current practising certificate, who commenced employment on audit day. An interview with the interim business and care manager confirmed they have been working for Oceania group as a manager at another Oceania facility and are now in a relieving position managing Oceania facilities, where this is required. The interim business and care manager is supported in their role by a clinical manager / RN and the Oceania quality and clinical manager (RN).  All staff requiring practising certificates have current practising certificates, sighted.  The facility has contracts with Christchurch District Heath Board (CDHB) for aged related residential care for hospital, rest home and aged related residential respite care.  The relevant District Health Board contract requirements are met |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There are quality and risk management systems in place including clinical risk management policy and plan and quality improvement policy. There is ongoing surveillance and monthly reporting on clinical risks including accidents/incidents and sentinel events.  An internal audit schedule and completed audits for 2014 were reviewed. There was evidence the internal audits results are collected, collated, evaluated, and analysed to identify trends, however the corrective action plans are not consistently recorded or implemented following identified shortfalls from internal audits. The residents and family satisfaction survey evidenced the results were collated, however there was no evidence of actions taken in response to the survey results and this requires an improvement.  Quality and risk management data and quality improvement data is reported at facilities meetings, sighted.  The policies and procedures reflect current accepted good practice and reference legislative requirements. Document control policy and procedure for new or reviewed documents is recorded and implemented. Staff interviews confirm staff are informed of new / updated policies.  The health and safety manual documents health and safety management systems including health and safety policy and plan, employee participation, health and safety audits, accident reporting, injury management, hazard management, contractor management and emergency plan. Oceania holds Workplace Safety Management Practices at tertiary level for ACC workplace safety and this expires on 31st March 2015.  Not all relevant District Health Board contract requirements are met. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is a policy on incident/accident and sentinel event reporting. All accident/incidents are recorded and reported on the Oceania intranet as part of the monthly clinical indicators that record incidents relating to absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse.  Communication with families following adverse events, or any change in resident’s condition was evidenced in the residents’ files reviewed (refer to 1.3.3.3). Family interviews confirmed they are informed of any adverse events or change in resident’s condition.  Staff interviews confirmed awareness of the adverse event process.  Staff are made aware of their essential notification responsibilities through their job descriptions, Oceania policies and procedures and professional codes of conduct.  The relevant District Health Board contract requirements are met. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are policies and procedures in relation to human resource management. The annual practising certificates are current for all staff who require them to practice.  The Oceania’s training programme caters for all of the roles within the organisation and is intertwined with the Oceania Career Pathway Programme (CPP). There is an Oceania training planner that maps out courses and dates that staff can book into and this is used alongside the clinical in-service sessions provided at the facility.  An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff interviews confirmed orientation / induction is provided for new staff. Care staff also confirmed their attendance at on-going in-service education.  The relevant District Health Board contract requirements are met. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There are documented staffing rationale policies for determining staffing levels and skill mixes. Staff interviews confirmed staff are able to get through their work.  The interim business and care manager (RN) is employed full time, Monday to Friday, confirmed at interview with both the interim business and care manager and the clinical and quality manager. The staff roster evidenced the clinical manager (RN) is employed full time from Monday to Friday each week. There are nine registered nurses and four enrolled nurses employed at the facility. The clinical and quality manager stated the current vacancies were for the business and care manager, two health care assistants, one administrator and one part time kitchen assistant. The positions have been advertised and interviews are in progress. The registered nurse cover is 24 hours a day, seven days a week. A planned schedule for on call after hours and weekends is implemented.  The relevant District Health Board contract requirements are met. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Medicines were dispensed and delivered by the pharmacy. All medicine prescribed were signed by the general practitioner (GP). Each resident file reviewed had an individual medicines profile and medicine prescription form with an individually dispensed rolls of medicines and medicine signing sheets. The GP, with input of the registered nurse completed medicine reconciliation on admission for each resident.  A controlled drug register was maintained in the hospital area and evidenced weekly registered nurse and six monthly pharmacy stock takes and checks. The controlled drugs are stored securely. The service did not have standing orders. The medicines requiring refrigeration were stored in dedicated fridges, kept in secure rooms. The medicines fridge temperatures were recorded on a daily basis and were within the recommended temperature range for medicines.  Medicine reviews by the GPs were recorded in the medicine charts and reviewed three monthly, confirmed in 10 medicine files reviewed. There is evidence staff were signing off, as the dose was administered, observed during the medication round in the hospital.  Staff responsible for medicine management received on-going education, and had current medicine competencies signed off. Medicines were observed to be managed in a safe and appropriate manner. The medicines policy included self-administration of medicines. There were no residents self-administering their own medicine.  The contractual requirements of the District Health Board are met. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Food, fluid, and nutritional needs of residents were provided in line with recognised nutritional guidelines. Additional requirements and modified dietary needs were being met. The resident's individual needs were identified on admission, documented in nutrition and dietary profiles, and reviewed. Menus were planned and annually reviewed by the dietitian. Interview with the cook confirmed the cook's knowledge of individual resident's likes and dislikes, preferences and special diets.  Resident interviews reported the food service was adequate and confirmed that their preferences are being met. Adequate fluids were provided and snacks were available between meals. Additional supplements were offered to residents who were under-weight. Short term care plans were used for residents who experience unintentional weight loss. Residents' files sampled demonstrated regular monthly weighing.  Residents’ person centred care plans identified nutritional needs and interventions to achieve these goals are documented. Residents are referred to their GP or the dietitian for investigation when unintentional weight loss is experienced. Residents with swallowing difficulties may also be referred to a speech language therapist when required.  Visual inspection of the kitchen and food preparation areas evidenced the areas were maintained and clean. Fridge and freezer and food temperatures were monitored daily.  Interview with the cook confirmed kitchen staff received education on safe food handling requirements, chemical safety and infections control. Food supply is obtained from a national provider. Emergency food and water supply was stored at the facility.  The contractual requirements of the District Health Board are met. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Five resident care plans were reviewed and risk assessments checked. The residents’ care plans recorded interventions, support and care needs. The previous requirement for improvement relating to care plans having to reflect interventions is fully implemented.  The contractual requirements of the District Health Board are met. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documentation and observations made of service provision and/or interventions demonstrated that consultation and liaison is occurring with other services. All of the five residents' files reviewed provided evidence that care plans record appropriate interventions. Interventions were based on the assessed needs, desired outcomes or goals of the residents. The general practitioner’s (GP) documentation and records were current. Visual inspection of the service evidenced adequate continence and dressing supplies in accordance with requirements of the Service Agreement. The residents and family interviews confirmed care and treatments meet their needs. The family communication sheets record contact and communication with family.  The contractual requirements of the District Health Board are met. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The review of residents’ records evidenced that staff complete and review the activities programme for each area of the service. The satisfaction survey results confirmed that residents and their families were satisfied with the activities delivered at the facility. The residents in both areas of the service were actively engaged in activities during the on-site visit. An interview with the activities coordinator confirmed that residents receive weekly activities programmes and have a variety of activities to choose from.  The documentation reviewed and interviews of staff, family, and the GP provided evidence that the activities contribute to the residents being more active and stimulated. The activities in the rest home included social activities in the community and interview with residents confirmed the activities contributed to their quality of life and helping to maintain their independence. The residents in the hospital and rest home reported they enjoy the van outings, and activities observed during the audit were well attended.  The contractual requirements of the District Health Board are met. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The residents' files reviewed evidenced that care plans were evaluated within stated timeframes, at least six monthly. The care plan evaluations were conducted by the registered nurses (RN) with input from the other RN’s, the resident, family, care staff and activity staff. The families were notified of changes in resident's condition, evidenced in all five residents' files reviewed.  The residents and family interviews confirmed their participation in care plan evaluations and review. There was recorded evidence of input from professional, specialist and multi-disciplinary sources, for example nurse practitioners, physiotherapist, podiatrist and the dietitian. The residents' files evidenced referral letters to specialists and other health professionals, where this was required. The short term care plans were in place for short term changes in condition. The updated care plans reflected changes in the condition of residents.  The contractual requirements of the District Health Board are met. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The clinical and quality manager advised there have not been any alterations to the building since the last audit. A building warrant of fitness is displayed at the main entrance and expires 20 June 2015.  The residents have access to external areas that are appropriate to their needs.  There was evidence a preventative maintenance plan is in place and reactive maintenance was occurring. Medical equipment checks were conducted by an external contractor and testing and tagging of electrical equipment was occurring. Visual inspection indicated there is safe storage of medical equipment.  Corridors are wide enough to allow residents to pass each other safely. Safety rails are secure and are appropriately located. Floor surfaces/coverings are appropriate to the resident group and setting.  Staff receive education in the safe use of medical equipment and there is a system in place to review staff competency for specific equipment; for example hoists competency. This was confirmed interview by clinical staff and review of staff education records.  The District Health Board contract requirements are met. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Documentation review provided evidence that the surveillance reporting process is applicable to the size and complexity of the organization. Surveillance was aligned with the organisation’s ‘Infection Control Policy'.  All infections were recorded as quality indicators on intranet. Residents with infections had short term care plans completed to ensure affective management and monitoring of infections. Quality indicators were reported monthly at the health and safety, staff, registered nurse (RN) and health care assistant (HCA) meetings, and care meetings.  Interviews confirmed this information is made available for all clinical staff during hand over and meetings. Infections were expressed in graph form and included in the monthly reports to the Oceania Support Office. The organisation participated in internal and external benchmarking. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrated that residents were experiencing services that are least restrictive. Enablers and restraints evidenced consents, assessments, monitoring and review documentation.  The contractual requirement of the District Health Board is met. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.7  Advance directives that are made available to service providers are acted on where valid. | PA Moderate | The service was able to demonstrate that written consent is obtained, however the ‘Not for Resuscitation’ orders were not signed by the residents. | ‘Not for Resuscitation’ orders were signed by enduring power of attorneys (EPOA’s) | ‘Not for Resuscitation’ orders may only be signed by residents who are cognitively able to make their own decisions.  30 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The internal audit schedule, completed audits and satisfaction surveys were reviewed. There were some audit results and facility’s meeting minutes that evidence corrective actions are addressed, however not all identified shortfalls are being consistently addressed. | The internal audits and satisfaction surveys that identify shortfalls do not consistently evidence documented corrective action plans, implementation of corrective action plans, management sign off and communication of same to all concerned. | Provide evidence the identified shortfalls following internal audits and satisfaction surveys record corrective action plans and that these corrective action plans are implemented, signed off by management and communicated to all concerned.  180 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | A care review was conducted of a resident who had an un-observed fall. Review of the file showed that staff did not complete neurological observations for the resident, as per policy. Interviews with staff confirm when residents have un-observed falls, neurological observations are to be routinely completed to identify possible head injuries. | A clinical file review evidenced neurological observations were not completed for a resident who suffered an unobserved fall. | Staff to ensure they complete neurological observations for all residents that have un-observed falls.  90 days |

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

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

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

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

|  |
| --- |
| No data to display |

End of the report.