# Oceania Care Company Limited - Woburn Rest Home

## Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Woburn Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 16 August 2016 End date: 17 August 2016

**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:** 30

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

## General overview of the audit

Woburn Rest Home (Oceania Care Company Limited) can provide care for up to thirty three residents requiring care at either rest home or dementia level. At the time of the on-site audit there were twenty two residents receiving rest home care and eight residents receiving dementia care.

This certification audit has been undertaken to establish compliance with the relevant Health and Disability Services Standards and the district health board contract. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

The business and care manager, who is also the clinical manager, is responsible for the overall management of the facility and is supported by the regional and executive management team. Service delivery is monitored. Improvements are required in corrective action planning and medication management.

## 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. |

Staff interviewed were able to demonstrate understanding of residents' rights and their obligations during cares, including their responsibilities relating to the complaints process. Information regarding the complaints process is available to residents and their family. Complaints reviewed are investigated with documentation completed and stored in the complaints register. Staff communicate with residents and family members following any incident, with this recorded in the resident file. Residents and family state that the environment is conducive to communication including identification of any issues.

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

Woburn Rest Home has documentation of the Oceania Care Company Limited quality and risk management system that supports the provision of clinical care and support, including dementia level of care. Policies are reviewed and business status reports allow for the monitoring of service delivery. Benchmarking reports include clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented. Corrective action plans are documented.

Staffing levels are adequate across the service with human resource policies implemented. This includes evidence of recruitment and staffing. Rosters indicate that staff are replaced when on leave. The service has implemented an orientation and training programme for all staff.

## Continuum of service delivery

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

Service provision is coordinated to promote continuity of service delivery. The residents and family interviewed confirm their input into care planning and access to a range of life experiences and choices. Residents' clinical files validated service delivery. Residents’ care planning is changed according to the needs of the resident when progress is different from expected. The service uses short term care plans for the management of acute problems. Residents have interRAI assessments completed and updated. The residents and family interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Medication areas, including controlled drug storage, evidence a secure medicine dispensing system. Review of staff competencies confirmed all staff have current medication management competencies. One resident self-administers medicines. Self-administration of medicines occurs according to policy.

The facility utilises four weekly rotating summer and winter menus, reviewed by a dietitian. Food services are appropriate and meet legislative requirements.

## Safe and appropriate environment

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

There is a current building warrant of fitness. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family interviewed describe the environment as appropriate, with indoor and outdoor areas that meet their needs.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. There were no residents using restraint or requiring enablers on audit days.

Staff education in restraint, de-escalation and challenging behaviour has been provided.

## 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. |

Surveillance of infections is occurring according to the provider’s policies. Policy is appropriate for their size and service type. Data on the nature and frequency of identified infections is collected, collated and analysed. The results of surveillance are reported through all levels of the organisation. The service reports infection surveillance data as part of key quality information to the governing body. The service participates in benchmarked against other Oceania Care Company Limited facilities.

## 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 | 43 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 2 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Residents stated they receive services according to their needs and rights. Posters identifying residents’ rights are displayed in the facility. Staff are able to explain rights for residents in a way that promotes choice.  Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during induction to the service and as part of the annual mandatory training and education programme.  The auditors noted respectful attitudes towards residents and their families. All staff have had consumer rights training over the previous twelve months. Interviews with staff confirmed their understanding of the Code and ways the Code is implemented in their everyday practice, for example; maintaining residents' privacy; encouraging independence and ensuring residents could continue to practice their own personal values and beliefs. |
| 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. | FA | There is an informed consent policy and procedure that directs staff in relation to obtaining of informed consent. All resident files identified that informed consent is collected and recorded. Interviews with staff confirmed their understanding of informed consent processes.  The service information pack includes information regarding informed consent. The registered nurse, the clinical manager or the general practitioner discuss informed consent processes with residents and their families during the admission process. The service has guidelines for consent for resuscitation/advance directives. Advanced directives in files reviewed are signed by residents deemed competent to complete these. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on the role of advocacy services is provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service and in information packs provided to residents and family on admission to the service. Staff training on the role of advocacy services is included in training on the Code and this was last provided in the previous twelve months prior to the audit.  Discussions with family and residents identified that the service provides opportunities for the family/enduring power of attorney to be involved in decisions. Interviews with residents and family confirmed they have been informed about advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to maintain community interests and involvement. Residents reported they are supported by staff to access health care services outside of the facility. The activities programme includes regular outings and participation in community events. Community groups and entertainers visit the facility. The service welcomes visitors, and has unrestricted visiting hours. Family members state they feel welcome when they visit. Residents confirm they are able to have visitors of their choice. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisation’s complaints policy and procedures are in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include periods for responding to a complaint. Complaint forms are available in the foyer of the facility.  A complaints register is in place and the register includes: the date the complaint was received; the source of the complaint; an overview of the complaint; actions taken during the investigation of the complaint; overview of the corrective actions taken and the date the complaint was resolved. Complaints were tracked and the review indicated that all timeframes taken to inform the family and resolve the issues raised were met.  Residents and family members stated that they would feel comfortable complaining, should they need to do so. There have not been any complaints forwarded by the Health and Disability Commission or to any other external authority. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | During the admission process, new residents and their family are provided with a copy of the Code and information on the Nationwide Health and Disability Advocacy Service. The business and care manager advised this information is discussed with the resident and their family.  Residents and family members interviewed were familiar with the Code and the advocacy service. Residents and family stated they would feel comfortable raising issues with any of the staff and management, including complaints. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes dignity, respect and quality of life. The service policies and procedures are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents’ support needs are assessed using a holistic approach. The initial and ongoing assessments identify people’s beliefs and values. Care plans are completed with the resident and family member contributing to the process. Interventions to support these are identified and evaluated. Resident files reviewed identified that cultural and/or spiritual values and individual preferences were identified.  Policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner. The policy provides strategies to manage inappropriate behaviour when it occurs. The service ensures that each resident has the right to privacy and dignity. The residents’ personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room. The service also provides areas in the facility which can be used to meet in private.  Health care assistants report that they knock on bedroom doors prior to entering rooms. To promote privacy staff ensure doors are shut during personal cares and staff do not hold personal discussions in public areas, this was observed on the days of the audit. Residents and families confirmed that residents’ privacy is respected.  The service is committed to the prevention and detection of abuse and neglect. Staff receive annual training on abuse and neglect and can describe signs and different forms of abuse and neglect. There are no documented incidents of abuse or neglect in the business status reports for 2015 or in the incidents reviewed in residents’ files. Residents, staff, family and the general practitioner confirm that there is no evidence of abuse or neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has a Māori health plan that guides staff in meeting the needs of residents who identify as Māori. The business and care manager confirmed networks have been established locally with service providers who can provide additional support to residents who identify as Māori. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan.  Specific cultural needs are identified in the residents’ care plans through the completion of a cultural assessment. Staff are aware of the importance of whānau in the delivery of care for the Māori residents. There were no residents identifying as Māori residing in the facility during the on-site audit. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Interview with the chaplain confirmed residents are seen on admission and when spiritual service is requested. Residents and family members advised they are consulted about their individual ethnic, cultural, spiritual values and beliefs in an ongoing manner.  Residents’ personal needs, individual preferences, values and beliefs are identified on admission and recorded in the care plans reviewed. Residents and family are involved in the assessment and the care planning processes.  Staff are familiar with how translating and interpreting services can be accessed. At time of audit there were no Pacific Island staff employed at Woburn but there were Maori staff who ensured the service focusses on cultural awareness. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility implements the Oceania Care Company Limited (Oceania) policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. The contractual agreements with employees include standards of conduct. Residents and family members state that they are free from any type of discrimination or exploitation.  The staff induction and orientation programme include information relating to discrimination and there is regular training for all staff on the topic. Staff demonstrated an understanding of what would constitute inappropriate behaviour and are familiar with the processes to be followed should a resident be experiencing abuse and or neglect. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has established professional networks to help ensure residents receive services of an appropriate standard, including specialist services at the local district health board (DHB). The policies and procedures reflect best practice and these are available to guide staff in care delivery.  There is a mandatory annual training and education programme for all staff. Managers working for Oceania are encouraged, by the support office, to complete management training. Registered nurses (RN) and clinical managers are supported to attend external education sessions by the organisation.  Consultation is available through the organisation’s management team that includes the clinical and quality manager; regional operations manager and a dietitian. The managers attend regional management meetings. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accidents/incidents, the complaints process and the open disclosure procedure alert staff to their responsibility to notify family or the enduring power of attorney of any accidents/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is practiced.  When a resident has an incident, accident or change in their health needs, family are informed as confirmed in a review of accident/incident forms, progress notes and communication records in the residents’ files. Interviews with family members confirmed they are kept informed. Family confirmed that they are invited at least six monthly to attend care planning meetings.  Interpreting services are available, when required, from the district health board. There were no residents requiring interpreting services at the time of the audit.  All residents interviewed confirmed that staff are approachable and communicate in a way that meets their needs. The business and care manager has an open door policy that allows residents, family and staff to communicate any issues at any time. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Woburn Rest Home is part of Oceania Care Company Limited with the executive management team including: the chief executive; general manager; regional manager; operations manager and clinical and quality manager providing support to the service. Communication between the service and the managers takes place on at least a monthly basis.  The senior clinical and quality manager and the operations manager provided support during the audit. The monthly business status report provides the executive management team with progress against identified indicators. Oceania Care Company Limited mission, values and goals are communicated to residents, staff and family through posters on the wall, information in booklets and in annual staff training and education.  The facility can provide care for up to 33 residents with 30 beds occupied at the time of audit. Occupancy included twenty two residents requiring rest home level care and eight residents requiring dementia level care. There were no residents identified as being under the young people with disability contract.  The business and care manager, who is also the clinical manager, is responsible for the overall management of the service. The registered nurse (RN) has been in the role for twelve weeks and previously completed the competency assessment programme (CAP) for RNs who are new to the country. The RN completed the CAP course in another aged care facility of the Oceania Care Company. The business and care manager is a RN and has more than thirty years of experience in management and aged care. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the business and care manager, the clinical quality manager stands in with support from the regional operations manager and senior clinical and quality manager. |
| 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 | Woburn Rest Home uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice. The business plan is documented and reporting occurs through the business status reports. Reporting includes: financial monitoring; review of staff costs; progress against the healthy workplace action plan; review of complaints; incidents; relationships and market presence action plan and review of physical products.  The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews, as required, with all policies current. Policies are linked to the Health and Disability Sector Standard, current/applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff and new and revised policies are signed by staff to confirm they have read and understand the policies. The policy relating to pressure injuries has been reviewed and is ratified. The service is focusing on preventing pressure injuries with a literature review completed and strategies introduced to improve service delivery. Staff state they have had the policy circulated to read.  There are monthly meetings with minutes documented that include: management; health and safety; staff; quality; registered nurse and resident and family meetings. All staff interviewed reported that they are kept informed of quality improvements. Service delivery is monitored through: complaints; review of incidents and accidents; surveillance of infections and implementation of an internal audit programme. Quality improvement data is analysed through meetings and benchmarking. There is a requirement for improvement relating to corrective actions plans not consistently reflecting the specific actions to be taken to resolve the issue, who the person is to implement the changes and by when the changes are expected to be implemented.  The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service, which include a documented hazard management programme and a hazard register for each part of the service. Any hazards identified are signed off as addressed or risks are minimised or isolated.  There is a six monthly satisfaction survey for residents and family. The 2015 surveys indicate that residents and family are satisfied with services provided. This was confirmed through interviews with family and residents on the days of audit. |
| 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 | The business and care manager is aware of situations when statutory authorities need to be informed including: police attending the facility; unexpected deaths; critical incidents; pressure injuries as per guidelines and infectious disease outbreaks. Times when authorities have had to be notified are documented and retained on the relevant file.  The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff records reviewed demonstrate that staff receive education at orientation on the incident and accident reporting process. Staff interviewed understand the adverse event reporting process and their obligation to documenting all untoward events.  Incident reports selected for review had a corresponding note in the progress notes to inform staff that the incident occurred. There is evidence of open disclosure for recorded events. Information is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania Care Company Limited facilities. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resource policy and processes are in place and implemented. The registered nurse and the business and care manager hold current annual practising certificates. Staff files include employment documentation such as: job descriptions; contracts; and appointment documentation on file. Criminal vetting is completed and an annual appraisal process is in place with all staff files reviewed having a current performance appraisal on file.  All staff participate in the induction and orientation programme at the start of their employment. Staff are able to articulate the buddy system in place and the competency sign off process is completed as required. Training is identified on an annual training and education programme. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training held. Staff records include attendance at training sessions. The annual training and education programme includes training relating to core service delivery topics such as: medication management; restraint; infection control; health and safety; manual handling and continence management. The registered nurse and business and care manager completed training around pressure injuries management.  There is one registered nurse (the business and care manager) who has completed interRAI , with another registered nurse enrolled in training.  Staff working in the dementia unit completed dementia education and training as required by the aged residential care contract. The training register and training attendance sheets record staff completion of annual medication and other competencies such as hoist; oxygen use; hand washing; wound management; moving and handling; restraint; nebuliser; blood sugar and insulin. Education and training hours exceed eight hours a year for staff files reviewed. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy drives work-force planning. Staffing levels are reviewed for anticipated workloads, appropriate skill mix and changes in the services. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy. Staff working in the dementia unit completed the required training for this level of care.  There are 32 staff, including clinical staff, staff who facilitate the activities programme and household staff. There is always a registered nurse on in the mornings and the business and care manager is on call 24/7. Residents and families interviewed confirm staffing is adequate to meet the residents’ needs. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are policies and procedures in place for privacy and confidentiality of residents’ information. Relevant resident care documentation can be accessed in a timely manner. The service retains relevant and appropriate information to identify residents and records. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Archived records are securely stored and easily retrievable.  All components of the residents’ records reviewed include the residents’ unique identifiers. The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Medication charts are kept separate from residents’ files. Resident files and medication charts are accessed by authorised personnel only.  Residents’ progress notes are completed on every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes identify the name and designation of the person making the entry. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Entry and assessment processes are recorded and implemented, confirmed during the business and care manager and the administrator interviews. The facility information pack is available for residents and their family on admission and contains all relevant information. The service provides dementia level of care for up to eleven residents, with eight residents on the days of audit.  The residents' admission agreements evidence resident and/or family and facility representative sign off. The admission agreement defines the scope of the service and includes all contractual requirements. The needs assessments are completed for rest home and dementia levels of care. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is appropriate communication between families and providers, that demonstrate transition, exit, discharge or transfer plans are communicated, when required. At the time of transition, appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the residents’ progress notes. |
| 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. | PA Low | Medication areas, including controlled drug storage evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stocktakes. The medication fridge temperatures are conducted and recorded.  Current medication competencies for staff who administer medicines were sighted. The medication round was observed and evidenced the staff member was knowledgeable about the medicines administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures.  Medication audits have been conducted and corrective actions are implemented following the audits. There was one resident self-administering medicines at the facility and this was conducted according to policy.  Medicine charts list all medications the resident is taking, including name, dose, frequency and route to be given. There is a requirement for improvement relating to the GP not consistently completing recording the dates of when medication is commenced. Allergies are recorded. All residents have photo identification. Discontinued medicines are identified. The three monthly GP reviews were not all completed within the three monthly timeframes. Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored daily. |
| 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 | In interview, the cook confirmed they were aware of the residents’ individual dietary needs. The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service and reported their individual preferences are met and adequate food and fluids are provided. Interview with the cook confirmed kitchen staff have completed food safety training, and this was verified by their food safety certificates.  On inspection, the kitchen environment was clean, well-lit and uncluttered. There was evidence of kitchen cleaning schedules, signed off as cleaning is completed. Fridge, chiller and freezer temperatures are monitored regularly and recorded, as are food temperatures. There is a seasonal menu, last reviewed by a dietitian during April 2016. Review of residents’ files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as: special diets, pureed meals, and alternative nutrition, appropriate to the residents are available. The kitchen provides 24/7 snacks for residents in the dementia unit. There was enough stock to last in an emergency situation, for three days, for all residents. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | There is a process for informing residents, their family/whānau and their referrers if entry to the service is declined. Reasons for declining entry are communicated to the referrer, resident and their family or advocate in a timely and compassionate manner that is easily understood. Where requested, assistance is given to provide the resident and their family with other options for alternative health care arrangements or residential services. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission, residents have their needs identified through a variety of information sources including: the needs assessment and service coordination (NASC) agency; other service providers involved with the resident; the resident; family/whānau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. The business and care manager undertakes an interRAI assessment; other assessments are completed by the registered nurse. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The residents’ care plans are individualised, integrated and up to date. The care plans record assessment findings and describe the required support and interventions the resident needs to meet their goals and desired outcomes.  Care plans evidence service integration with progress notes, activities notes, and GP and allied health staff notations clearly written. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interview.  Short term care plans are developed, when required, and signed off by the RN when problems are resolved. In interviews, staff reported they receive adequate information for continuity of residents’ care. The residents and their family have input into their care planning and review. |
| 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 residents' person’s centred care plans (PCCP) evidence the required interventions, desired outcomes or goals of the residents. In interviews, residents and family confirmed their and their relatives’ current care and treatments meet their needs. Family communication is recorded in the residents’ files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated. |
| 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 service employs two activity coordinators (AC) who are responsible for residents’ activities. In interview with one of the ACs, they confirmed the activities programme is available to all residents in the rest home and dementia unit. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations. Resident and family meetings are conducted bi-monthly. Residents in the dementia unit all have 24-hour activities plans for the management of challenging behaviour. Activity plans and programmes are reviewed by a diversional therapist from another Oceania facility and signed off as appropriate.  There are activities assessments and activities care plans in residents’ files reviewed. Activities care plans in the residents’ files reviewed had intervention relating to the activities goals. The residents’ activities attendance records are maintained as are activities progress notes. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Time frames in relation to care planning evaluations are documented and implemented. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.  The residents’ progress records are entered on each shift. When resident’s progress is different than expected, the RN contacts the GP, as required. Short term care plans were sighted in some of the residents’ files, and these are used when required. The family are notified of any changes in resident's condition, confirmed at family interviews.  There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. All referrals are documented in residents’ clinical files.  Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance, if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes are in place for the management of waste and hazardous substances and these are implemented. Material safety data sheets provided by a chemical representative are available and accessible to staff. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances. During the on-site visual inspection of the service it was confirmed that hazardous substances are: correctly labelled; safely stored; protective clothing and equipment is available; and staff use the protective clothing and equipment. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose.  There is a preventative and reactive maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Testing and tagging of electrical equipment and calibration of biomedical equipment is current. Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use any equipment.  The physical environment for residents in the dementia unit allows for wandering and is spacious and specific to their needs. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible toilets/bathing facilities. Toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.  Handrails are appropriately secured and provided in the toilet/shower/bathing areas. Other equipment/accessories are made available to promote resident independence. Residents and family members reported that there are sufficient toilets and showers with some rooms in the rest home area having their own ensuite.  Auditors observed residents being supported to access communal toilets and showers in ways that are respectful, dignified and provided privacy. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is adequate personal space provided in bedrooms to allow residents and staff to move around within the room safely. Residents interviewed spoke positively about their rooms. Equipment was sighted in rooms requiring this with sufficient space for both the equipment and the resident and the ability to include emergency equipment in the room, if required.  Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own. The facility provides room to store mobility aids, such as walking frames, in the bedroom, safely, during the day and night, if required. The ability to support residents and to engage residents socially was considered when identifying the resident and bedroom on admission. Adequate dining and lounge areas are provided in the rest home and in the dementia unit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has lounge and dining areas, including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The dining areas have space for all residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry policies and procedures are documented and implemented. There are processes in place for linen changes and collection and delivery of residents’ personal clothing. The effectiveness of the cleaning and laundry services is audited through the internal audit programme. The cleaner described the cleaning processes during interview.  There are safe and secure storage areas and staff have appropriate and adequate access to these areas, as required. Chemicals are labelled and stored safely within these areas. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility. Residents and families stated they were satisfied with the cleaning and laundry services. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems are in place for essential, emergency and security services.  The service has a New Zealand Fire Service letter approving the fire evacuation scheme, this was sighted during the on-site audit. Trial evacuations are held six monthly. Emergency and security management education is provided at orientation and as part of the in-service education programme. Information in relation to emergency and security situations is available and displayed. The dementia unit is securely maintained through the use of pin-code locks on access doors. The emergency equipment is accessible, stored, current for use, and stocked to a level appropriate to the service setting.  There is a call bell system in place that is used by the residents, family and staff members to summon assistance, when required. Call bells are available in all resident areas. Call bells are monitored by the maintenance staff monthly. Residents confirmed they have a call bell system in place, which is accessible and staff respond to it in a timely manner.  The service is prepared for the management of an emergency by having barbeque cooking facilities, flashlights and other battery operated lighting equipment and water. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There are no residents at the facility that smoke. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The Oceania Care Company Limited (Oceania) infection control policies and procedures manual provides information and resources to inform staff on infection prevention and control.  The responsibility for infection control is clearly defined in the infection control policy that includes: responsibilities of the Oceania infection control committee (company–wide); infection control nurse (ICN) and the infection control team responsibilities. There is a signed ICN job description outlining responsibilities of the position. The ICN is the business and care/clinical manager. There is evidence of regular reports on infection related issues and these are communicated to staff and management.  The Oceania wide infection control programme is reviewed annually by the Oceania infection control committee (company–wide). The facility’s infection control programme is reviewed annually by the infection control team at the facility. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICN has access to relevant and current information which is appropriate to the size and complexity of the service, including but not limited to: an infection control manual; internet; access to experts; and internal and external education for staff.  Infection control is an agenda item at the facility’s meetings, evidenced during review of meeting minutes and interviews with staff. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interviews. The infection control policies and procedures are developed and reviewed regularly in consultation and input from relevant staff, and external specialists. Infection control policies and procedures identify links to other documentation in the facility. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control education is provided to all staff, as part of their orientation and as part of the ongoing in-service education programme. In interviews, staff advised that clinical staff identify situations where infection control education is required for a resident such as: hand hygiene; cough etiquette; and one on one education are conducted. The infection control staff education is provided by the ICN and external specialists. Education sessions have evidence of staff attendance/participation and content of the presentations. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews. |
| 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 | The documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organization. Surveillance is aligned with the organisation’s policies. Infections are recorded as quality indicators on the intranet.  Residents with infections have short-term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on monthly at staff, quality, and infection control and health and safety meetings. Interviews confirmed information relating to infections is made available for clinical staff during hand over and at staff meetings.  The ICN is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at staff meetings. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. In interview, the ICN confirmed no outbreak occurred at the facility since last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler is congruent with the definition in the standard. There is a job description for the position of the restraint coordinator, who is the business and care/clinical manager.  Staff interviews and review of documentation, demonstrated knowledge of safe use of restraint and enablers. The service has a policy of actively minimising restraint. The service has a documented system in place for restraint and enabler use, including a current restraint register showing no restraint at this time. There were no restraints or enablers being used in the facility on audit days. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (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 | Service delivery is reviewed three to six monthly, depending on the needs of the residents. There is a document control system in place to manage the policies and procedures. Key components of service delivery are linked to the quality management system. Quality improvement data is collected, analysed, and evaluated and the results communicated to staff. The service has a process in place to measure their achievements against the quality and risk management plan. Corrective action plans address areas requiring improvement, however these plans do not consistently reflect the changes to be implemented, the person responsible for the implementation of changes and by when the changes need to be in place. | Corrective action plans do not consistently record;  i) corrective actions to be implemented,  ii) who the person is to implement the changes and  iii) by when these changes are expected to be implemented. | Corrective action plans to record;  i) corrective actions to be implemented,  ii) identify the person who is responsible for the implementation of the changes and  iii) to identify the date by when these changes are expected to be implemented.  60 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | The service implemented a medicines management system to manage prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation. Service providers responsible for medicine management are competent to perform the function.  The medicines management processes comply with legislation, protocols, and guidelines; however the medicine management information is not consistently recorded to the level of detail, as required. The dates of when the GP prescribed new medicines are not consistently recorded on the medicines administration sheets. | The commencement dates of medicines are not consistently recorded on medicines administration sheets. | Medicines to be recorded to a level of detail to comply with legislation, protocols and guidelines.  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.

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End of the report.