# Oceania Care Company Limited - Raeburn

## 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:** Raeburn

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

**Dates of audit:** Start date: 17 November 2014 End date: 17 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:** 53

# 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

Raeburn is part of the Oceania Group. This surveillance audit was undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Raeburn provides residential hospital, dementia and rest home level care for up to up to 66 residents with 53 residents during the audit.

There is a new management team (business and care manager and clinical manager) who are receiving support from the Oceania clinical and quality manager.

Eight of nine improvements required at the last certification audit around the abuse and neglect policy, management plans for residents with challenging behaviour, care planning, medication administration, electrical checks, hot water monitoring and restraint have been addressed.

One improvement continues to be required around trial evacuations.

There are improvements required to staffing overnight in the rest home and safety in the kitchen in the dementia unit.

## 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 were able to demonstrate an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties and caring for the residents. Information regarding resident rights, access to advocacy services and how to lodge a complaint was available to residents and their family and complaints were investigated. Staff communicated with residents and family members following any incident.

The improvement required at the certification audit around the abuse and neglect policy has been addressed.

## 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 medium or high risk and/or unattained and of low risk. |

Raeburn has implemented the Oceania quality and risk management system that supported the provision of clinical care and support. Policies were reviewed and business status reports allowed monitoring of service delivery. Quality improvement included review of clinical indicators, incidents/accidents, review of audit reports, satisfaction surveys, infections and complaints. Corrective action plans were documented with evidence of resolution in response to issues raised.

Staffing levels were documented with rosters indicating that staff when on leave were replaced. An improvement is required to staffing in the rest home area overnight.

## Continuum of service delivery

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

Systems and processes are implemented to assess, plan and evaluate the identified needs of residents requiring rest home, hospital and dementia care. Staff are trained and qualified to perform their roles and deliver all aspects of service delivery. The two clinical managers oversee the care and management of all residents along with the team of registered nurses, one enrolled nurse and the health care assistants. All residents are assessed on admission and assessment details are retained in the individual residents` records.

The person centred care plans are reviewed six monthly or more often if and when required. The resident and family are involved in the care planning and review. Documentation was reviewed within timeframes as required for the service.

The activities programme is developed and implemented to maintain the interests, skills and independence of the residents. It is voluntary to attend the sessions or outings arranged in the community. The programme is displayed in all areas of the facility.

Medication management systems comply with current legislation and all staff involved in medicine management undergo a competency assessment annually. The general practitioners review all medications and work alongside a contracted pharmacy.

The food service is managed by an experienced service provider. The menu plans have been reviewed. A copy of the dietary requirements for each individual resident was obtained on admission and any special needs are met. All staff working in the kitchen have completed relevant food safety training. Meals are provided at appropriate times of the day.

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

There is a current building warrant of fitness in place. There was a planned and reactive maintenance programme in place with issues addressed as these arose. Residents and family described the environment as meeting their needs.

Improvements required at the certification audit around checking of electrical equipment and hot water temperatures have been met.

An improvement continues to be required to completion of fire/emergency drills.

An improvement is required to safety in the kitchen around use of appliances in the dementia unit.

## 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. |

The service has a commitment to a policy and philosophy of `non-restraint` and appropriate use of restraint/enablers, should these be required. Clear definitions in the policy reviewed ensure staff understand the implications of restraint and enabler use. Restraint and enablers are only used as a last resort. Enablers are only used as a voluntary measure and consent is obtained. Monitoring occurs and is recorded to meet all requirements of the restraint standard. Safety of residents is paramount and always considered by the approval team.

## 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. |

Monthly surveillance data was adequately recorded, collated and reported by the infection control co-ordinator to management. Analysis and evaluation of data was used for organisational benchmarking purposes and to develop any corrective actions required which are monitored in a timely manner. Any feed-back was displayed in all service areas and provided to the staff at the staff meetings. The surveillance system was well maintained and is appropriate for the size and types of services provided at this aged residential care facility.

## 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 | 19 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 45 | 0 | 2 | 1 | 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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisation’s complaints policy and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes time-frames for responding to a complaint. Complaint’s forms are available in all parts of the service including the dementia unit.  A complaints register is in place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint’s folder.  Two complaints lodged in 2014 were selected for review. There is documented evidence of time-frames being met for responding to these complaints with documentation indicating that the complainants are happy with the outcome.  All five residents (two rest home and three hospital) and five family members state that they would feel comfortable complaining.  All complaints are captured in the complaints register as confirmed on interview with two family who state that complaints made have been addressed and recorded appropriately.  Staff have had training around management of complaints September 2014.  The District Health Board contract requirements are met. |
| 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 | There is a policy around abuse and neglect. Residents, family and staff state that there is no evidence of abuse and neglect.  Staff are able to describe a process for reporting of any incidents related to abuse and neglect if identified.  The abuse and neglect policy includes reference to the Crimes Amendment Act (3) 2011. The previous improvement required at the certification audit has been addressed. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available.  Family are informed if the resident has an incident, accident, has a change in health or a change in needs with this documented in ten completed accident/incident forms and in the resident files.  Family contact is recorded in residents’ files – sighted in six of six resident files reviewed.  Interviews with five family members confirm they are kept informed. Family interviewed also confirm that they are invited at least six monthly to the care planning meetings for their family member with this is confirmed on the multi-disciplinary form.  Family interviewed confirm that they are invited to attend the resident meetings.  Interpreter services are available when required from the District Health Board. There are no residents currently requiring interpreting services and all residents interviewed confirm that staff are approachable and communicate well.  The information pack is available in large print and advised that this can be read to residents.  Staff have had training around communication in May 2014.  The 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 | Raeburn is part of the Oceania group with the executive management team including the chief executive officer, general manager, operations manager, regional operational managers and the clinical and quality manager providing support to the service.  Communication between the clinical and quality manager and the business and care manager takes place on a monthly basis with more support provided as required (confirmed by the quality and clinical manager and business and care manager interviewed).  Oceania has a clear mission, values and goals. The vision is to be the provider of choice for senior New Zealanders of care and lifestyle options in a way that meets and exceeds the expectations of our residents, staff and stakeholders. The mission is ‘we provide excellent contemporary care that reflects our residents’ individuality and their right to choice, respect and dignity. We provide a positive and welcoming environment in which our residents are encouraged and supported to improve their quality of life’.  The facility can provide care for up to 66 residents with 53 residents occupying beds in the service. During the audit there are 19 residents requiring rest home level of care, 20 requiring hospital level of care and 14 in the dementia unit.  The business and care manager is responsible for the overall management of the facility. The business and care manager (a registered nurse) has been in the role for four weeks and has over 17 years experience in aged care facilities. The clinical manager provides clinical oversight and has 17 years experience in the armed forces in a nursing capacity.  The 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. | FA | Raeburn uses the Oceania quality and risk management framework that is documented to guide practice. The business plan is documented and reported on through the business status reports. This 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. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff. New and revised policies are presented to staff to read and staff sign to stay that they have read and understood – sighted and confirmed by the three health care assistants interviewed.  All staff interviewed including three health care assistants, the activities coordinator, the maintenance staff, the clinical manager and two registered nurses report they are kept informed of quality improvements.  The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures, and a health and safety plan are in place for the service. There is a hazard management programme documented 2013-14 with a hazard register for each part of the service. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated. The maintenance staff confirm their role in managing and addressing hazards.  The organisation holds a current ACC Work Safety and Management Practice tertiary level accreditation.  There is a Community Connect newsletter from the organisation thyat is circujlated to residents and family. This provides news about the service and Oceania.  The last resident/family satisfaction survey is collated (completed last in July 2014) and the service has a corrective action plan documented. A collated report from the survey indicates that residents and family are satisfied overall. The general practitioner also states that there is a high level of satisfaction with the service.  Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme noting that improvements identified as being required have a corrective action plan documented and evidence of resolution of issues documented in meeting minutes particularly in the quality and risk meeting minutes and other meeting minutes when these are documented.  There are meetings held across the service including monthly quality and risk meetings, health and safety, registered nurse, health care assistant, housekeeping and staff, meetings. There are three monthly restraint meetings. There are a number of opportunities for residents and family to have input into the service through monthly meetings.  The 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 | The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. At no time since the last audit have authorities needed to be notified. There have been no outbreaks since the last audit.  The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the business and care manager and clinical and quality manager.  Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.  Ten incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared through the monthly meetings with documentation of incidents which are then graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. The results are displayed in the staff room and registered nurses and health care assistants describe sighting these and reviewing trends.   The 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 | All registered nurses, the clinical manager and business and care manager hold current annual practising certificates. Visiting practitioner’s practising certificates include the general practitioner, dietitian, podiatrist and physiotherapist and a review during the audit confirms that these are current.  Seven staff files reviewed include appointment documentation on file including signed contracts, reference checks and interviews. There is an annual appraisal process in place with all staff having a current performance appraisal. First aid certificates are held in staff file along with other training records.  Police checks are completed – sighted in all employee files reviewed apart from those staff who have been employed more than five years ago.  All staff undergo an orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract. Health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and health care assistants who administer medicines to residents. Other competencies are completed including hoist, oxygen use, hand washing, wound management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower.  There is a training plan that is implemented in 2014 with attendance records maintained.  The health care assistants state that they value the training. Education and training hours exceeds eight hours a year for all staff reviewed.  Staff working in the dementia unit have completed the dementia training or if new, are enrolled in the training once orientation is completed.  The 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. | PA Moderate | The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents.  There are appropriate numbers of health care assistants on morning and afternoon shifts with staff rostered onto the hospital and dementia unit overnight. The two health care assistants in the dementia unit include one who is able to support staff in the hospital with any cares required overnight. They are also required to support residents in the rest home. There is a potential risk of staff being busy overnight in the hospital and dementia unit and of not recognising that the fourteen residents in the rest home area need assistance. The roster was adjusted to base the second health care assistant from the dementia unit in the rest home area overnight on the day of the audit.  There are currently 45 staff including the business and care manager, the clinical managers, seven registered nurses and 25 health care assistants. There has been a 50% staff turnover in 2014 and the new management team is recruiting into roles currently with bureau staff addressing gaps in the roster when staff are on leave.  An improvement is required to staffing overnight in the rest home area.  The District Health Board contract requirements are partially 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 | The medicine management policy for the organisation provides guidance on medication reconciliation, prescribing, ordering, checking, storage, administration, and documentation of medications. The process of disposing expired/unwanted medications is also noted. Residents have a right to refuse medications. Where a resident refuses medications which was the case in the one of the tracers provided this is documented and communicated. Errors are required to be reported via the incident reporting system. The management of controlled drugs is included and includes weekly checks of balances and six monthly quantity stock counts occur. No residents are currently self-administer medicines but there is a process in place should this occur. There is evidence of the GPs reviewing the medications three monthly or more often if and when required. The GP dates and sign off the discontinued medication (this is an area of required improvements from the previous audit that is closed out).  Twelve medication records are randomly selected for review, four from each area of service delivery. All medication record sheets are documented appropriately and dated and signed as required. All records have photo identification on all pages. This is an improvement from the previous audit that is closed out. Each medication is prescribed individually. There is a specimen signature register maintained for all staff who administer medications.  There are documented competencies sighted for all staff designated as responsible for medicine management. The two registered nurses administering medicines at the time of the audit demonstrate competency related to medication management.  Standing orders are used at this facility and meet legislative requirements.  The DHB requirements 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 | The food services policies and procedures are documented for the organisation. An assessment is conducted when a resident is admitted to identify any dietary needs and food preferences. The policy details the principals of food safety, ordering, storage, cooking, reheating and food handling. Infection prevention and control requirements for the kitchen staff employed are also detailed. Guidance is provided on portion sizes, pureed foods, soft diets, diabetic diets and other information can be accessed. Practices to clean the kitchen and associated equipment are included. The kitchen cleaning schedule was reviewed.  The trained Chef has worked at this facility for eighteen months, is experienced in aged care, hospitality and tourism. A kitchen hand is available five days a week. The chef interviewed reports they are supported by management and respond to any concerns expressed by residents relating to food.  There is a four week rotating menu with summer and winter variations. The menu is reviewed by the organisation`s dietitian (sighted).  A dietary sheet is completed by the registered nurse as part of the assessment process. Any areas relating to food allergies and/or sensitivities, likes and dislikes, portion sizes are reported to the chef and a copy of the assessment is retained by the chef. A whiteboard is utilised in the kitchen to remind staff when preparing the food. Special diets managed well. Special events, celebrations such as anniversaries and birthdays are catered for with cakes and special morning and afternoon teas.  All aspects of food procurement, production, preparation, storage, delivery and disposal comply with legislation and guidelines. The chef completes all of the ordering of food stuffs and checks all deliveries on arrival and ensures foods are stored appropriately. The chiller, fridges and freezer temperature recordings are maintained daily by the chef and kitchen staff to meet food safety requirements. The kitchen staff have completed food safety management education appropriate to service delivery in an aged residential care facility.  Residents and staff at interview are satisfied with the food service.  The DHB requirements are met. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Four randomly selected resident files of residents in the dementia unit had clear evidence of challenging behaviour management plans. The plans are documented in conjunction with the person centred care plan to guide staff on how to manage the individual resident during times of challenging behaviour. The pre-admission interRAI assessments and the initial assessments on admission are taken into consideration when the registered nurses are gathering the information to document the individual person centre care plans and setting appropriate interventions to meet the goals to be effectively met over the 24 hour period.  The improvement required at the previous audit has been effectively closed out. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The service delivery plans are integrated and evidence continuity of service delivery for all services provided being rest home, hospital and dementia level care. The was an improvement identified in 1.3.4.2 in relation to the residents in the dementia unit and their challenging behaviour plans not providing adequate intervention information over the 24 hour period for managing any episodes of challenging behaviour and promoting continuity of service delivery. Refer to 1.3.4 and this has now been closed out. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Policies and procedures are available for managing all aspects of service delivery. As observed in the individual resident files selected the support and care is flexible and individualised and the person centred care plans focus on the promotion of independence and quality of life. The registered nurses and health care assistants interviewed demonstrate good knowledge and skill in managing service delivery for residents of the three level of care provided at this facility. The individual files reviewed evidence consultation and involvement of the family or representative. The residents interviewed report that the service provides the support and care required to meet their individual needs.  The service has adequate dressing and continence supplies to meet the needs of the residents. The person centred care plans reviewed record interventions that are consistent with the residents` assessed needs and desired goals. Observations on the day of audit indicate residents are receiving care that is consistent with the residents` needs. The clinical staff interviewed report that the person centred care plans are accurate and up to date to reflect the interventions and goals set. Outcomes are discussed at the time of the care plan review to ensure the resident`s goals are able to be met. The improvement required at the previous audit has been closed out.  The DHB requirements 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 weekly activities plan was reviewed and is developed based on the resident`s needs, interests, skills and strengths. The activity co-ordinators assist with the planned activities seven days a week, with the programme that is developed and implemented. The main activities co-ordinator works 35 hours a week. Another staff member assists with activities and is also the physio-aide for five hours a week. The weekly programme is displayed in each resident`s individual room and on the monthly planner is displayed in the rest home, hospital and the dementia unit.  The activities programme covers cognitive, physic and social needs. The activities are modified to suit the individual needs and capabilities of each resident. `My memory journey` is completed which focuses on sensory activities and reminiscence. The activities co-ordinator verified that the programme developed and implemented provided a sense of well-being, belonging and a sense of purpose.  Activities and participation is encouraged though staff interviewed are aware that atte4ndance is voluntary and activities planned reflect normal life interests and are meaningful. The activities co-ordinator at interview reports that flexibility to change the activities occurs based on the resident`s response.  The service provides easy access to outside areas that enable the resident to wander freely and safely. There is a courtyard that allows the dementia unit residents to wander safely. A separate programme is available in the dementia unit.  The residents` files reviewed in the dementia unit have activities and social assessments that identify the resident`s individual diversional, motivated and recreational requirements over a 24 hour period.  The residents interviewed report they enjoy a range and variety of planned activities. Links with the community is encouraged. Groups are welcome to entertain on an arranged basis and outing in the community are arranged. Consent for van outings is obtained on admission and cultural needs are considered at all times. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The residents` files reviewed have a documented evaluation that has been conducted within the past six months. Evaluations are reviewed for all of the issues in the care plan. These evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the goals set. The multidisciplinary reviews are held six monthly and all key staff contribute to this process.  If a resident is not responding to the services being delivered, or their health status changes, then this is discussed with their GP. Short term care plans are developed and implemented as required for wound care, infections, pain management, changes in food and fluid intake and/or skin care. These processes are clearly documented on the short term care plan, medical and nursing assessments and in the progress records. The staff at interview demonstrate good knowledge of short term care plans and report that these are identified at time of handover between the shifts. Handover was observed. The SBARR assessment tool is an assessment and communication tool which had been introduced into this service by newly appointed management and staff report this is working effectively.  Family interviewed report they can talk with the newly appointed management and staff if they have any concerns or there are any changes in the resident`s condition.  The DHB requirements 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. | PA Low | A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 12 June 2015). There have been no building modifications since the last audit noting that refurbishments of rooms have continued.  There is a planned maintenance schedule implemented and the maintenance staff confirms implementation of this.  The lounge areas are designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounges on the day of the audit. The areas are suitable for residents with mobility aids with a secure unit for residents in the dementia unit. There are large gardens and outdoor areas including a secure outdoor area for the dementia unit.  The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programme and this is up to date (last completed September 2014). The improvement required at the previous audit has been addressed.  There is a kitchen in the dementia unit. Residents are able to access the oven (switch located in a cupboard) and a microwave. An improvement is required to ensure safety in the kitchen for residents in the dementia unit.  The District Health Board contract requirements are partially met. |
| 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 an adequate number of communal toilets and shower rooms in the service. Communal toilets and showers are spacious enough to be able to use mobility aids, shower stools and other appropriate equipment to tend to the resident’s personal hygiene requirements. There are engaged/vacant signage on the toilet/shower doors. Handrails are appropriately placed to support the resident. The residents interviewed state the staff are respectful and ensure their privacy and dignity is maintained when attending to their personal hygiene requirements.  The hot water temperatures in resident areas are maintained at 44-45 degrees Celsius including water temperatures in the showers. The improvement required at the previous audit has been addressed. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | There is a staff member on each shift who has a current first aid certificate. The register of first aid certificates is sighted.  Emergency training is conducted during orientation with all staff files reviewed indicating that an orientation that includes health and safety, hazardous substances, call bell system and emergency planning has been completed.  There is an expectation that staff have emergency evacuation drills six monthly. The service has provided emergency drills in October 2013 and July 2014. The newly appointed business and care manager is a fire officer and is aware of expectations. The improvement required at the previous audit remains outstanding. |
| 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 | Click here to enter text |
| 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 | There is a surveillance system which is well managed by the appointed infection control co-ordinator (ICC). The registered nurse interviewed was fully informed about the infection control surveillance available and undertaken at this facility. The clinical CPI summary sheet is completed monthly by the registered nurses. The laboratory and the contracted pharmacist send relevant information on infections and antibiotic usage each month which is significantly beneficial when collating the data.  Information is used for benchmarking with other Oceania facilities. Staff receive a copy of the graphs and summaries which is displayed in the staff room. Monthly comparisons can be viewed. The results of surveillance are reported back to management for the quality meetings. The surveillance programme is adequate for the nature of this aged care residential service. Any improvements or trends are acted upon if necessary.  All staff interviewed are required to take a responsibility for surveillance activities as described in policy. Monitoring is clearly described in the quality plan to ensure residents`, staff and visitors` safety at all times. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Raeburn operates on a documented philosophy of commitment to achieving and maintaining a restraint free environment, with enablers and restraint used as a last resort. The policy and procedure governing the safe use of restraint and the strategies in place to minimise the requirement for restraint is comprehensive, clear and well understood by all staff interviewed. It is acknowledged by staff that restraint is only used when absolutely necessary and when they have exhausted all other options. It is considered as a decision that is not made lightly and one based on a process of initial assessment and authorisation process, with an on-going process of assessment, monitoring and evaluation.  The policy clearly differentiates between enablers and restraint, the classifications of restraint, and specific information about the approved restraints in the facility. The restraint process is clearly linked to the challenging behaviour assessment. Enablers are used as a voluntary measure to promote resident safety. There are currently four enablers and four restraints used. Restraint meetings are held three monthly and each individual case is discussed. Meeting minutes are available and sighted.  All staff have access to and attend education on restraint and the management of challenging behaviour on orientation to the facility and through education sessions as part of the ongoing education programme.  The DHB requirement 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | There are appropriate numbers of health care assistants on morning and afternoon shifts with staff rostered onto the hospital and dementia unit overnight. The two health care assistants in the dementia unit include one who is able to support staff in the hospital with any cares required overnight. They are also required to support residents in the rest home. | The rest home is an ‘L’ shape with hallways leading to the hospital area where the registered nurse and the health care assistant are based overnight. Fourteen residents requiring rest home level of care are based in the rest home area and there is a potential risk of staff being busy overnight in the hospital and dementia unit and of not recognising that these residents need assistance. The roster was adjusted to base the second health care assistant from the dementia unit in the rest home area overnight. | Ensure that staff are based in the rest home area and responsive to residents overnight.  30 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | There is a kitchen in the dementia unit. Residents are able to access the oven (switch located in a cupboard) and a microwave. There is a snib lock on the inside of the door into the kitchen. A new lock was put on the cupboard where the oven switch is located on the day of the audit. | The switch for the oven is in a cupboard that is potentially able to be locked (unlocked on the day of the audit). The microwave is potentially able to be used by residents although the switch is behind the microwave. | Ensure residents are safe when they are in the dementia unit kitchen.  30 days |
| Criterion 1.4.7.1  Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Low | The orientation programme includes fire and security training. Staff confirm their awareness of emergency procedures.  There is an expectation that staff have emergency evacuation drills six monthly. The service has provided emergency drills in October 2013 and August 2014. The newly appointed business and care manager is a fire officer and is aware of expectations. | Emergency evacuation drills have not been completed six monthly as per policy. | Ensure that evacuation drills are completed six monthly as per policy  30 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.