# The Ultimate Care Group Limited - Oakland Lifecare

## Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** The Ultimate Care Group Limited

**Premises audited:** Oakland Lifecare

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

**Dates of audit:** Start date: 5 January 2015 End date: 6 January 2015

**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:** 74

# 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

Oakland Lifecare provides residential care for up to 84 residents who require rest home and hospital level care. The facility is operated by The Ultimate Care Group Limited.

The certification audit was conducted against the relevant Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of the policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

There was evidence of overall improvement in the facility’s systems and service delivery since the last on site audit and no areas were identified as requiring improvement during this audit.

## Consumer rights

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Care provided to residents at Oakland Lifecare was in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy were respected.

The service had appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided.

Residents felt safe, there was no sign of harassment or discrimination, staff communicated effectively and residents were kept up to date with information. Residents, or their enduring power of attorney, signed a consent form on entry to the service with separate consents obtained for specific events.

The service informed residents and their families of how to access the Nationwide Health and Disability Advocacy Service and encouraged residents and their enduring power of attorneys to maintain connections with family, friends and their community and encouraged people to access as many community opportunities as possible.

The acting facility manager was responsible for the management of complaints and a complaints register was maintained.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Oakland Lifecare. A ‘Quality and Risk Management Plan for Oakland Lifecare’ was reviewed and included a vision statement, values, quality objectives, quality and risk management plan, quality indicators and quality projects. Systems were in place for monitoring the service provided at Oakland Lifecare that included regular monthly reporting by the acting facility manager to The Ultimate Care Group Head Office. The facility was being managed by an acting facility manager who started in this role on the 3 November 2014 and was supported by an experienced clinical services manager/registered nurse who was responsible for oversight of clinical care.

The Ultimate Care Group quality and risk management systems were in place at Oakland Lifecare. There was evidence that quality improvement data was collected, collated, analysed to identify trends and corrective actions plans were developed and implemented. There was an internal audit programme, risks were identified, and there was a hazard register. Adverse events were documented on accident/incident forms and there was an electronic database that was able to be reviewed by personnel from The Ultimate Care Group Head Office.

There were policies and procedures on human resources management. All health professionals had current practising certificates. Inservice education was provided for staff through study days and this was supplemented by additional education sessions. Staff were also supported to complete the New Zealand Qualifications Authority Unit Standards through Careerforce. All staff had current performance appraisals. Review of staff records evidenced; human resources processes were followed and individual education records were maintained.

There was a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery, which was based on best practice. The minimum number of staff was provided during the night shift and consisted of two registered nurses and three caregivers. The team leaders/registered nurses were rostered on call after hours. All care staff interviewed reported there was adequate staff available and that they were able to get through their work.

Resident information was entered into a register in an accurate and timely manner.

## Continuum of service delivery

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

Information packs and web sites for the service contained information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. The organisation worked closely with the Needs Assessment Coordination Service to ensure access to the service was efficient, whenever there was a vacancy.

There was evidence that residents’ needs were assessed on admission by the multidisciplinary team. All residents’ files sighted provided evidence that needs, goals and outcomes were identified and reviewed on a regular basis with the resident, and where appropriate their family. Residents and families interviewed reported the care provided was of a high standard.

An activities programme, that included a wide range of activities and involvement with the wider community, was enjoyed by residents.

Well defined medicine policies and procedures guided practice. Practices sighted were consistent with these documents.

The menu has been reviewed by a registered dietitian and meets nutritional requirements, with any special dietary requirements and need for feeding assistance or modified equipment recorded and met. Residents had a role in menu choice. Interviews with residents verified satisfaction with meals, though at times meals required reheating to meet residents’ need and this is being addressed.

## Safe and appropriate environment

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

Apart from one double bedroom, accommodation for residents was provided in single bedrooms. Some bedrooms had shared ensuites and wash hand basins. Residents' bedrooms were of varying sizes and adequate personal space was provided.

Lounges and dining areas were available for residents to use. External areas were available for sitting and shading was provided. An appropriate call bell system was available and security systems were in place.

Visual inspection provided evidence of sluice facilities, safe storage of chemicals, soiled linen and equipment. Protective equipment and clothing was provided and used by staff. Review of documentation provided evidence that appropriate systems were in place to ensure the residents’ physical environment was safe and facilities were fit for their purpose.

Policies and procedures for waste management, cleaning and laundry, and emergency management were available and these were known by staff. All laundry was washed on site and cleaning and laundry systems included appropriate monitoring systems that evaluated the effectiveness of these services.

## Restraint minimisation and safe practice

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

There were nine residents using restraints and one resident using an enabler on the days of the audit. Policies and procedures, staff training and the implementation of the processes, demonstrated residents were experiencing services that were the least restrictive.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The service provided a well-managed environment, which minimised the risk of infection to residents, service providers and visitors. Reporting lines were clearly defined, with the infection control coordinator reporting directly to the clinical services manager.

There was a clearly defined infection prevention and control programme for which external advice and support was sought. An infection control nurse was responsible for this programme, including education and surveillance.

Infection control policies and procedures were reviewed annually. Infection prevention and control education was included in the staff orientation programme, annual core training and in topical sessions. Residents were supported with infection control information as appropriate.

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections was collated and analysed. Surveillance results were reported through all levels of the organisation, including governance.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 101 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The services provided by Oakland Lifecare complied with consumer rights legislation. Policy documents, plus the sighted staff orientation programme, in-service education training records, planned education programmes, interviews (with seven residents, three family members and fourteen staff) and resident/relative satisfaction surveys, verified staff knowledge of the Code of Health and Disability Services Consumers’ Rights (the Code).Clinical staff were observed to explain procedures, seek verbal acknowledgement for a procedure to proceed, protect residents' privacy (notes being locked away, confidentiality of information, cordless phone available to make phone calls and staff knocking on residents' doors prior to entering their rooms), and residents were addressed by a preferred name. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The informed consent policy clearly described all procedures to ensure the resident’s rights to be informed of all procedures undertaken. Residents’ choices were respected by Oakland Lifecare staff. Residents and their families were provided with the information needed to make informed choices and give informed consent.Admission documentation informed the resident and their family/whanau of inclusions and exclusions in service and requested consent to; collect and retain information, take a photograph for identification purposes, a name on a bedroom door and to travel in transport organised by the service. Residents were able to select their GP of choice. Informed consent was evident in observation of activities at audit, with residents being actively involved in the decision making process.Files reviewed evidenced informed consent was included in the admission agreement and identified the resident, and where desired family/whanau, are informed of changes in a resident’s condition, doctors’ visits, and care needs, including medication changes. Residents’ choices and decisions were recorded and acted on. Verbal consent was obtained prior to an intervention being carried out as observed and verified in clinical staff, resident and family interviews. Care plans were reviewed and signed by the resident or family/whanau, where appropriate, to say they had read and agreed with what was written. Staff education on consent takes place during orientation and in-service training sessions. Staff interviews verified understanding of the informed consent process, a resident's right to privacy, to be treated with respect and dignity, to be fully informed of all care procedures and the resident's right to decline to consent at any time.Interviews confirmed the necessary information was provided for residents to make informed choices and choices were respected by staff. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The service provided by Oakland Lifecare recognised and facilitated the rights of residents and their family/whanau to advocacy/support by persons of their choice. Residents have access to information on the Nationwide Health and Disability Advocacy Service and on admission were advised of their right to contact the Health and Disability Commissioner’s office if they felt their rights had been breached. A representative from the local Health and Disability Commissioner’s office attends residents meetings when requested. Advocacy information was observed in brochure format in the facility. The facility had open visiting hours. Residents and their families were free to access community services of their choice and the service utilised appropriate community resources, both internally and externally. Residents and their families were aware of their right to have support persons, as verified in staff, residents and family interviews. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents of Oakland Lifecare were assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations, with the support of the service. The service acknowledged values and encouraged the involvement of families/whanau in the provision of care, and the activities programme actively supports community involvement and accesses community resources. Resident and family interviews confirmed visitors visit freely and assistance was provided to access community services. Visitors were observed coming and going from the facility during the audit. File reviews, residents, families, facility manager, registered nurses, care assistants and the diversional therapist interviewed described a range of community services used by the facility. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The acting facility manager was responsible for complaints and there were appropriate systems in place to manage the complaints processes. A complaints register was maintained that included 21 internal complaints since the last audit. The complaints register was reviewed during this audit. The acting facility manager advised there had been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, District Health Board (DHB), Accident Compensation Corporation (ACC) or Coroner since the last audit.Complaints policies and procedures were compliant with Right 10 of the Code. Systems were in place that ensured residents and their family were advised on entry to the facility of the complaint processes and the Code. Residents and family interviewed demonstrated an understanding and awareness of these processes. Resident meetings were held monthly and residents were able to raise any issues they had during these meetings. This was confirmed during interview of residents and family and review of resident meeting minutes. Review of the collated October/November 2014 family survey evidenced families were satisfied with the response they received as a result of making a complaint.A visual inspection of the facility provided evidence that the complaint process was readily accessible and/or displayed. Review of quality and staff meeting minutes and the acting facility manager’s reports provided evidence of reporting of complaints to the governing body and staff. Care staff interviewed confirmed this information was reported to them via their quality and staff meetings. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The information and communication policy and the guidelines for communicating with residents, relatives and visitors provided guidance for staff to provide full information at entry to the service and as and when required during service delivery.Interviews with residents and families verified they were informed of their rights. Information on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service were displayed and accessible to residents.Residents received a copy of the Code in the admission enquiry pack provided by Oakland Lifecare. Discussion, clarification and explanation on the Code and the Nationwide Health and Disability Advocacy Service occurred at the time of admission. Legal advice is able to be sought on the admission agreement or any aspect of the service. Access to interpreters was available. The Nationwide Health and Disability Advocacy Service provided onsite training and an advocate was accessible at any time. Compliance with the standard was verified by, observation, documentation and interviews. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Policy identified procedures were in place at Oakland Lifecare to prevent abuse and neglect. Procedures to ensure resident privacy and dignity were also in place and identified actions taken to meet residents’ needs. This included spirituality and sexuality and clear management strategies for caregivers.Residents received services which treated them with respect, had regard for their dignity, privacy and independence and was responsive to their needs values and beliefs. Residents’ needs, goals, likes and dislikes were identified in the care plan. Interventions identify the assistance the resident required to maintain dignity and respect and to ensure sexuality; spiritual, cultural and intimacy needs are both supported and protected, while protecting the wellbeing of others.Residents were kept free from discrimination, harassment and abuse. The individual employment agreement, Code of Conduct, job description and company policies and procedures identified the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. Interviews verified there were no concerns expressed related to abuse or neglect. Residents had access to visitors of their choice and were supported to access community services. The environment enhances and encourages choice, opportunity, decision making, participation and inclusion of the resident, as evidenced by resident participation in the various initiatives. Staff working at Oakland Lifecare demonstrated responsiveness to residents’ needs, and this was verified by observation and interviews. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 | Documentation was in place at Oakland Lifecare to guide staff practices to ensure residents’ needs were met in a manner that respected and acknowledged their individual cultural, values and beliefs. Policy stated that this was to be identified upon entry as part of a resident’s care planning process. Whanau relationships and involvement in care were recognised. The organisation had a documented Maori Health Plan which identified their priorities related to culturally safe services. The service recognised the relationship between iwi and the Crown and the principles of the Treaty of Waitangi (Partnership, Participation and Protection). There were no residents at Oakland Lifecare who identified as Maori at the time of audit.The local iwi supports Oakland Lifecare in meeting the needs of Maori residents if required. Staff receive education in relation to cultural safety and the Treaty of Waitangi. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Policy identified that residents of Oakland Lifecare will receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values and beliefs. Residents and/or family/whanau interviewed verified residents were consulted about individual values and beliefs. Residents’ specific cultural, spiritual, values and beliefs were documented in the care plan, to ensure residents’ needs and objectives were attended to.Residents access spiritual support from the community if required. A weekly multi-denominational church service was sighted in the activities programme. Open visiting policy allowed family/whanau to visit when able. Evidence to support findings was observed, sighted in file reviews and staff training records and confirmed by interview.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policy indicated that residents at Oakland Lifecare were to be free from all forms of discrimination, coercion, harassment and exploitations. Residents, families and staff interviewed verified that residents were free of any discrimination, coercion, harassment, sexual, financial or other exploitation. Residents felt safe and received a high standard of support and assistance and reported there was no sign of harassment or discrimination. Staff communicated effectively and residents and family members were kept up to date. Orientation/induction processes informed staff on the Code, the house rules and the Code of Conduct. The staff job descriptions, employment agreement, company policies and house rules provided clear guidelines on professional boundaries and conduct, and informed staff about working within their professional boundaries. A signature acknowledging the terms related to this information was located in all employment agreements. The acting Facility Manager has the responsibility to action formal disciplinary procedure if there was an employee breach of conduct. The above was evidenced in staff files and verified in staff, resident and family interviews. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Oakland Lifecare provided an environment that encouraged good practice. Policies sighted were current, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies were reflective of current up to date practices, which were monitored and evaluated at organisational and facility level.Human resources were managed to employ competent employees. New employees completed a comprehensive orientation/induction programme that was relevant to the role they were undertaking. Staff records evidenced competent employment practices, orientation and training records.Care staff were trained or undertaking training in care of the older adult, in addition to training in managing challenging behaviours and de-escalation strategies. Observations verified staffs had appropriate skills. Registered nurses’ on-going education was supported by courses through the local training authority, the District Health Board and the specialist services that they operate. An in-service education programme is offered by Oakland Lifecare, which was monitored to ensure the key components of service delivery were covered to meet contractual requirements and residents' need. Staff interviewed, confirmed the orientation/induction education and training prepared them for their roles. Staff stated they were encouraged and supported to undertake education that assists in their roles.The registered nurses who administer medication had yearly assessments to determine competency, in addition to current first aid certificates. The diversional therapists and activities personnel, who provided activities and outings for the residents, had a current first aid certificate. Kitchen staff were qualified in Safe Food Handling.Interviews and resident satisfaction surveys indicated satisfaction with all aspects of the service, other than the food temperatures at the evening meal, which are being attended to (refer 1.3.13), as did an interview with a general practitioner (GP). The GP confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policy identified that interpreter services were available to residents of Oakland Lifecare and offered to residents with English as a second language.Residents and family interviews confirmed communication with staff was open and effective. Residents were consulted and informed of any untoward event or change in care provision and included in care reviews, as sighted in files reviewed. The service had an open disclosure policy which guided staff around the principles and practice of open disclosure. Education on open disclosure was provided at orientation and as part of the annual education programme. Staff interviewed confirmed their understanding of open disclosure. Communication with relatives was documented in the residents’ communication records. Incident forms evidenced families being informed when incidents occurred.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Oakland Lifecare. A 'Quality and Risk Management Plan for Oakland Lifecare – January 2015 to January 2016’ was reviewed and included a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Also reviewed were documented values, mission statement and philosophy, which were displayed. The service philosophy was in an understandable form and was available to residents and their family / representative or other services involved in referring clients to the service. The Ultimate Care Group had established systems in place which defined the scope, direction and goals of the organisation at UCG facilities, as well as the monitoring and reporting processes against these systems. There was an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place that comprised of two clinical services managers (CSMs), two regional managers, a facility manager, the chief clinical officer and clinical support advisor from UGC, who were responsible for reviewing clinical issues and policies and procedures following feedback from each of the UCG sites and from the governing body.Meeting schedules and minutes reviewed evidenced that monthly quality, staff, registered nurse (RN), and residents’ meetings were held. Meeting minutes were available for review by staff along with graphs of various clinical indicators. The acting facility manager (AFM) provided two weekly and monthly reports to the governing body. Reports included reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators.Oakland Lifecare had an acting facility manager (AFM) at the time of audit who started in this postion on the 3 November 2014. Prior to this appointment there was a facility manager who started on the 21 July 2014 and resigned on the 3 November 2014. The AFM had been in the position of senior administrator for Oakland Lifecare prior to the acting facility manager’s role. Part of the senior administrator’s role was responsibility for financal management, admission agreements, aspects of human resources, and managing the registers for staff competencies and performance appraisals. The AFM’s personal file was reviewed and included a letter of appointment to acting facility manager and a job discription for the acting facility manager’s role. The AFM at interview reported they had been in a number of management roles prior to working at Oakland Lifecare and had experience of working in a District Health Board in a support role for clinical services and in health of the older persons services. The AFM was supported by an experienced clinical services manager(CSM) / registered nurse (RN). The CSM has been in this position since May 2012 and was responsible for oversight of clinical care provided to residents. Support was also provided by the team leaders/RNs. The chief clinical officer, the clinical support advisor and the regional operations manager from UGC provided support as required.Oakland Lifecare was certified to provide medical and geriatric hospital level care, rest home level care and physical and / or intellectual disabilities residential care. There are 84 beds provided. There are two rest home beds in the Pohutukawa wing that are used for either rest home or hospital use. On day one of this audit there were 48 hospital residents, 26 rest home residents, including 11 residents aged less than 65 years with a physical and / or intellectual disability.Contracts with the DHB include aged related residential care (rest home and hospital services) and long term support – chronic health conditions (residential). The service also has a contract with the Ministry of Health to provide residential – non aged care and with Accident Compensation Corporation (ACC) to provide residential support services.  |
| 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 | There were appropriate systems in place that ensured the day-to-day operation of the service continued should the acting facility manager (AFM) and/or the clinical manager (CM) be absent. The CSM would relieve the AFM if they were absent and the senior nurse leader would relieve the CM if they were absent. Twenty four hour registered nurse (RN) cover was provided. The team leaders were on call after hours if required.Services provided met the specific needs of the resident groups within the facility. Job descriptions and interviews of the AFM and CSM confirmed their responsibility and authority for their roles.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management plan for 2015 to 2016 was reviewed and was used to guide the quality programme and included goals and objectives. There was an internal audit programme in place and completed internal audits for 2014 were reviewed, along with processes for identification of risks. Risks were identified, and there was a hazard register that identified health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. A Health and Safety Manual was available that included relevant policies and procedures.Monthly quality and various staff meetings were held along with monthly residents’ meetings. Meeting minutes were reviewed and these were available for review by staff. The acting facility manager’s operations reports to UGC head office were reviewed and included reporting on occupancy, staffing and human resources management, environmental and property reports, financial reporting and general comments. Reporting to UGC head office was via an electronic database which was used to input clinical indicators on a daily basis. Clinical indicators and quality improvement data was recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence that quality improvement data was collected, collated, analysed to identify trends and corrective actions developed, implemented and evaluated. Numbers of various clinical indicators and quality and risk issues were reported to staff. Meeting minutes and reports reviewed also provided evidence of discussion of any trends identified, as well as reporting on infection control and health and safety. Staff interviewed reported they were kept well informed of quality and risk management issues that included clinical indicators. Copies of meeting minutes and graphs of clinical indicators were available in the roster room for staff to review. Staff were required to read and sign any updated policies and procedures and these were kept in the roster room.Adverse events were documented on accident/incident forms and copies of these were retained in the residents’ files. The quality and education coordinator had initiated a quality improvement project for 2014-2015 concerning the need for more detailed information written on incident/accident forms following residents who experience a fall. The aim of the project was to improve base line data to reduce the number of falls by creating a safer environment, minimising the loss of mobility, and injury, and admissions to the DHB hospital.Relevant standards were identified and included in the policies and procedures manuals. Policies and procedures were reviewed that were relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly, including a policy for document update reviews and document control policy. The CAG from UCG was responsible for reviewing policies and procedures. Staff signing sheets demonstrated staff had been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirmed the policies and procedures provided appropriate guidance for the service delivery and they were advised of new policies / revised policies via meetings and a folder kept in the ‘roster room’. A Health & Safety Manual was available that included relevant policies and procedures. There was a hazard reporting system available as well as a hazard register. Chemical safety data sheets were available that identified potential risks for each area of service. Planned maintenance and calibration programmes were in place and were reviewed. All biomedical equipment had appropriate performance verified stickers and electrical safety stickers were current and observed in place.  |
| 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 | Staff were documenting adverse, unplanned or untoward events on an incident/accident form which were then recorded on the electronic database, and filed in residents’ files. An 'Incident Management Form' was used to document all incidents that were escalated to UCG head office. Data reviewed for 2014 included summaries of various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and ‘behaviour’. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. There was an open disclosure policy. Residents’ files reviewed provided evidence of detailed communication with families following adverse events involving the resident, or any change in the resident’s condition. This finding was confirmed during interviews of residents and family members, and review of the family survey for 2014 provided evidence that families were very satisfied with communication from staff at Oakland Lifecare. Staff confirmed during interview that they were made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct, which was confirmed via review of staff files and other documentation. Policy and procedures complied with essential notification reporting including health and safety, human resources and infection control.  |
| 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 | Written policies and procedures in relation to human resources management were reviewed during this audit. The skills and knowledge required for each position within the service was documented in job descriptions which outlined accountability, responsibilities and authority which were reviewed on staff files, along with employment agreements, reference checking, criminal vetting, completed orientations and competency assessments (as appropriate). Copies of annual practising certificates were reviewed for all staff that required them to practice and were current. The quality and education coordinator/RN and the clinical services manager were responsible for the education programme. The quality and education coordinator/RN was also the onsite Careerforce assessor and reported staff were encouraged to complete Careerforce education. Four staff study days were provided each year and staff were rostered that allowed attendance at one of these compulsory study days each year. The quality and education coordinator/RN advised during interview that in-service education was also provided monthly to supplement these study days. Review of the education programme for 2014 and 2015 confirmed this. Review of staff files evidenced; competency assessments were current for all staff as appropriate.An appraisal schedule was in place and current staff appraisals were sighted on all staff files reviewed. An orientation/induction programme was available and all new staff were required to complete this prior to their commencement of care to residents. The CSM advised that staff were orientated for at least three shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, took up to three months to complete and staff performance was reviewed at the end of this period. Orientation for staff covered the essential components of the service provided. Care staff interviewed confirmed they had completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There was a clearly documented rationale for determining service provider levels and skill mixes so that a safe service was provided at Oakland Lifecare. The staffing rationale is based on 'SNZ:HB 8163:2005 Indicators for Safe aged-care and dementia-care for Consumers' - 'Table 4 Recommended hours per consumer'. ‘The Ultimate Care Group Rostering Tool’ was used by the acting facility manager to report to UCG head office. Registered nurse cover was provided 24 hours a day. The minimum number of staff was provided during the night shift and consisted of two registered nurses and three caregivers. The team leaders/RNs were rostered on call after hours and this was clearly displayed on the roster for staff.Care staff interviewed reported that there was enough staff on duty and they were able to get through the work allocated to them. Residents and family interviewed reported there was enough staff on duty that provided them with adequate care. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Resident information was entered in an accurate and timely manner into a register on the day of admission. Resident files were integrated and recent test/investigation/assessment information was located in residents' files. Approved abbreviations were listed. Residents’ files reviewed provided evidence that residents’ clinical records were integrated, and entries were made on each shift that were dated, signed and the time of entry documented.A visual inspection of the facility provided evidence that residents' information was stored in staff areas and was held securely and was not on public display. Clinical notes were current and accessible to all clinical staff. The resident's NHI number, name, and date of birth were used as the unique identifier. Clinical staff interviewed confirmed they knew how to maintain confidentiality of resident information. Historical records were held securely on site and were accessible. |
| 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 | When the need for services by Oakland Lifecare had been identified, it was planned, coordinated and delivered in a timely and appropriate manner.Information about the service included full details of the services provided, its location and hours, how the service was accessed, and identified the process if a resident required a change in the care provided. If the family chooses the service as the appropriate place, a planned admission process is commenced. The admission agreement was provided, prior to admission, enabling an opportunity to seek guidance/legal advice. Files reviewed contained completed assessments. Signed admission agreements met contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Exit, discharge or transfer from Oakland Lifecare was managed in a planned and coordinated manner, with an escort. The resident family/whanau was fully informed. There was open communication between all services, the resident and the family. At the time of transition appropriate information was supplied to the person/facility responsible for the ongoing management of the resident. There was a specific transfer/discharge form that recorded all the relevant information needed when transferring a resident. If the resident was transferring to a DHB or another facility, a verbal handover was given. All referrals were clearly documented in the progress notes. Evidence was sighted in files reviewed and verified by interviews. |
| 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 | Policy and procedure described current good practice related to medicine management at Oakland Lifecare. This included prescribing, dispensing, administration, review, storage, disposal and reconciliation processes. Medicines for residents were received from the pharmacy in a pre-packaged delivery system. A safe system for medicine management was observed on the days of audit. Staff who administered medicines had current medication competencies. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Controlled drugs were stored appropriately. Controlled drugs, when administered, were checked by two nurses for accuracy in administration. The controlled drug register evidenced weekly stock checks and accurate records.The records of temperatures for the medicine fridge had readings documenting temperatures within the recommended range. The medicine chart was signed individually by the GP. The GP’s signature and date was recorded on the commencement and discontinuation of medicines. Residents’ photos, allergies and sensitivities were recorded on the medicine chart. Sample signatures were documented. Medicine charts reviewed had completed medicine charts and signing sheets including approved abbreviations when a medicine had not been given. The three monthly GP review was recorded on the medicine chart. Medication errors were reported to the clinical services manager and recorded on an incident form. Incident forms recording drug errors were few and evidenced errors managed appropriately. The resident and/or the designated representative were advised.One resident at Oakland Lifecare self-administered an inhaler. Documentation and processes in place to support practice is in line with safe practice guidelines. Standing orders were in use at Oakland Lifecare. The written authorisation was signed by the resident’s GP, and identified the directions and indications for each medicines use. The standing order specified the medicines that may be administered under the standing order, the treatment and condition to which the order applies, the recommended dose range, the number of doses the standing order allows, the contraindications for use, the method of administration and the documentation required. Standing orders were reviewed yearly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food, fluid and nutritional requirements of the residents was provided in line with recognised nutritional and food safety guidelines.The effectiveness of chemical use, cleaning, and food safety practices in the kitchen was monitored by an external provider. The facility received monthly reports and recordings on the effectiveness of the programme. A cleaning schedule was sighted as was verification of compliance. There is evidence to support sufficient food was ordered and prepared to meet the residents’ recommended nutritional requirements. A dietary assessment was undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements were known to the cook and accommodated in the daily meal plan. Special equipment, to meet residents’ nutritional needs was sighted. Previous dissatisfaction with meal quantity and quality was improving, as verified by interviews. Sighted satisfaction surveys (9 October 2014), resident interviews and resident meeting minutes noted an ongoing dissatisfaction with meal temperatures particularly in the evening. Management was aware and corrective actions were in place to address this concern. Microwaves were available in all wings to make meals hotter for residents at their request. There was sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed. The dining rooms were clean, warm, light and airy to enhance the eating experience.When food was delivered it was checked for the ‘use by date’ and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, and cooked meat temperatures were monitored daily. Records sighted verified records were within accepted parameters. |
| 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 | An interview with the clinical services manager at Oakland Lifecare verified a process existed for informing residents, their family/whanau and their referrers if entry was declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services. Reasons for declining entry in the past were related to service not offering the services the resident required. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | There were policies, procedures and recognised assessment tools (such as the Braden Scale for pressure area risk) for all aspects of clinical care available for staff use when assessing a resident’s needs at Oakland Lifecare. Residents falls risks was ascertained upon entry to the facility and updated three monthly or more often if required. The nurse leader (RN) had assessed the residents within 24 hours of admission, gathering data from the resident, their family/nominated representative, the needs coordination services assessment and previous provider’s care services to the resident. In addition to this, data was gathered from a range of clinical assessments carried out by the RN. Within three weeks a long term care plan, based on the collection of more comprehensive assessment data, was developed. The plan directed the ongoing care required to meet the resident’s needs and desired outcome. Residents’ ongoing assessments, review and evaluations were completed and documented by the RN every three months or as a resident’s need changed, in consultation with the resident, family and allied professionals. The service was in the process of reassessing all residents using the interRAI assessment tool, in addition to the present tools being used.A medical assessment was conducted by the resident’s general practitioner (GP) of choice, within 24 hours of admission, and the medical treatment programme required by the resident was documented. Ongoing medical and pharmaceutical review were undertaken by the GP either monthly or three monthly if the medical practitioner deemed the resident to be stable. This took place in the privacy of the resident’s bedroom or the whanau room with the resident and/or family/whanau present if requested. Evidence of this was sighted in files reviewed. Resident and family interviews, verified they were included and informed of all assessment updates and changes. Staff interviewed confirmed they used observation and the information in the care plan to deliver the care the resident required. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The care plans at Oakland Lifecare were developed in consultation with the resident and/or family/whanau and described the required support the resident needed to meet their goals and desired outcomes. Evidence of the care provided was sighted in files reviewed. Progress notes, activities notes, medical and allied health professionals notations were clearly written, informative and relevant to the care provided. Any change in care required was written down in progress notes and the resident's care plan and verbally passed on to those concerned. Short term care plans documented the existence of short term problems and the required interventions. Care plans were evaluated three monthly or more frequently as the resident's condition dictated. Resident and family interviews verified they were included in the planning of their care. The staff education records sighted demonstrated that staff received appropriate training. The RNs participated in education sessions offered by the local training establishment and by the DHB. Staff were observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit. The facility had access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Files reviewed, observations and interviews with staff verified the provision of care provided to residents was consistent with residents’ physical, social, spiritual, behavioural and emotional needs and desired outcomes. Interventions were detailed, accurate and met current best practice standards.Interviews with residents and family/whanau members expressed satisfaction with the care provided.There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents’ needs. |
| Standard 1.3.7: Planned ActivitiesWhere 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 | A planned activities programme was sighted at Oakland Lifecare and aimed at developing and maintaining residents’ strengths and interests as identified in the activities assessment. The planned activities programme sighted, met the needs of all residents, as verified by interview, and was run by two diversional therapists and an activities officer.On admission, residents were assessed to ascertain their needs and appropriate activity requirements. The activities assessments and plans included the resident’s preferences, social history, and past and present interests. Activities assessments were analysed to develop an activities programme that was meaningful to the residents. Activities reflected ordinary patterns of life and included normal community activities. Family/whanau and friends were welcome to attend all activities and were welcome to visit their relatives. Individual activity assessments were updated or reviewed at least three monthly with a monthly summary of the resident’s response to the activities, level of interest and participation recorded. The goals were developed with the resident and their family, where appropriate, as evidenced by file reviews, resident and family interviews.A residents’ meeting was held monthly and meeting minutes evidenced that the activities programme was discussed. The yearly resident/relative satisfaction survey (October 2014) also captured feedback on the activities programme. Residents and family were satisfied with the activities offered. The diversional therapist interviewed reported feedback is sought from residents during and after activities. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ care was evaluated daily and reported in the progress notes. If any change was noted this was reported to the RN. Formal care plan evaluations measuring the degree of a resident’s response in relation to desired outcomes and goals occurred every three months or as a resident’s needs changed and were carried out by the RN. Where progress was different from expected, the service was seen to respond by initiating changes to the service delivery plan. A short term care plan was initiated for short term concerns, such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans were reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.Evidence of evaluation was sighted in files reviewed. Resident and families interviewed verified they were included and informed of all care plan updates and changes.  |
| 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 | If the need for other non-urgent services was indicated or requested, the GP or nurse leader sends a referral to seek specialist service provider assistance from the after-hours service or the DHB. Referrals were followed up on a regular basis by the registered nurse or the GP. The resident and the family were kept informed of the referral process. Residents were supported to access other health and/or disability support services, and when possible a family member and a staff member accompanied the resident. Acute/urgent referrals were actioned immediately, sending the resident to accident and emergency in an ambulance, with an escort, if the circumstances dictated. Families were informed, as sighted in files reviewed and verified by interviews. |
| 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 | There were documented processes in place for the management of waste and hazardous substances including specifying labelling requirements. Material safety data sheets provided by the chemical representative were available and accessible for staff. Education on chemical safety had been provided for staff in 2014. Staff interviewed reported they had received training and education that ensured safe and appropriate handling of waste and hazardous substances.Visual inspection of the facility provided evidence that hazardous substances were correctly labelled, and the containers were appropriate for the contents including container type, strength and type of lid/opening. Sluice facilities were provided for the disposal of waste, and protective clothing and equipment that was appropriate to the risks associated with the waste or hazardous substances being handled were provided and were being used by staff, including gloves, aprons and masks. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The maintenance person at interview confirmed there was a maintenance programme in place that ensured buildings, plant and equipment were maintained to an adequate standard. This finding was confirmed during visual inspection of the facility and review of maintenance documentation.Planned and reactive maintenance systems were in place and were reviewed during this audit along with current calibration/performance verified stickers that were observed on medical equipment. Electrical safety tags were viewed on electrical items. Service provider's documentation and visual inspection evidenced a current Building Warrant of Fitness that expires 6 January 2016.A visual inspection of the facility provided evidence of safe storage of medical equipment. Corridors were narrow in parts and residents were observed safely passing each other. Safety rails were secure and are appropriately located. The external areas were maintained, were safe and were appropriate to the resident groups and setting. Residents were protected from risks associated with being outside including provision of adequate and appropriate seating and provision of shade that ensured a safe area was available for recreation or evacuation purposes.Care staff interviewed confirmed they had access to appropriate equipment, equipment was checked before use, and they were competent to use the equipment.Residents interviewed confirmed they knew the processes they should follow if any repairs/maintenance was required and that requests were actioned in a timely manner. Residents interviewed confirmed they were able to move freely around the facility and that the accommodation met their needs.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 | Bedrooms had wash hand basins and there were adequate numbers of communal toilets and wash hand basins for residents. Toilets and showers were of an appropriate design and number that met the needs of the residents. The fixtures, fittings, floors and wall surfaces were constructed from materials that can be easily cleaned. Hot water temperatures were monitored three monthly and were 45 degrees Celsius or below.Toilets had appropriate access for residents based on their needs and abilities. Communal toilets and showers had a system that indicated if it was vacant or occupied. Appropriately secured and approved handrails were provided along with other equipment/accessories that were required to promote resident independence. |
| 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 | Apart from one double bedroom, all bedrooms provided single accommodation and were personalised to varying degrees. Visual inspection provided evidence that bedrooms were of various sizes and adequate personal space was provided in bedrooms that allowed residents and staff to move around safely. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Visual inspection provided evidence that adequate access was provided to the lounges, sitting areas and dining rooms. Residents were observed moving freely within these areas. Residents interviewed confirmed there were alternate areas available to them if communal activities were run in one of these areas and they did not want to participate in them. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There were policies and procedures available for cleaning and laundry and the safe storage and use of chemicals / poisons.All laundry was washed on site and there was adequate dirty / clean flow. The laundry person was interviewed and described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.Visual inspection of the facility provided evidence of implementation of appropriate cleaning and laundry processes. The effectiveness of the cleaning and laundry services was audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The chemical representative also provided reports during their monthly visits.Visual inspection of the facility provided evidence that: safe and secure storage areas were available and staff had appropriate and adequate access to these areas as required; chemicals were labelled and stored safely within these areas; chemical safety data sheets or equivalent were available; appropriate facilities exist for the disposal of soiled water/waste (ie, sluice rooms, convenient hand washing facilities were available, and hygiene standards were maintained in storage areas).Residents and family interviewed stated they were very satisfied with the cleaning and laundry services and this finding was confirmed during review of the collated satisfaction survey results for October/November 2014. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems were in place for essential, emergency and security services. Policy and procedures documented service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification were available. There were also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors. A New Zealand Fire Service letter was reviewed that advised the evacuation scheme was approved on 3 November 2006. The last trial evacuation was held 28 July 2014. There was at least one staff member on duty with a current first aid certificate. Emergency and security management education was provided as part of the study days held three monthly. Staff interviewed confirmed this.Processes were in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement. A visual inspection of the facility provided evidence that: information in relation to emergency and security situations was readily available / displayed for service providers and residents; emergency equipment was accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen and suction was maintained in a state of readiness for use in emergency situations. A visual inspection of the facility evidenced availability of emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones. There was a call bell system in place that was used by residents or staff members to summon assistance if required and was appropriate to the resident group and setting. Call bells were accessible / within reach, and were available in residents’ areas. Residents interviewed confirmed they had a call bell system in place which was accessible and staff responded to it in a timely manner.  |
| 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 | There were procedures that ensured the service was responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family interviewed confirmed the facility was maintained at an appropriate temperature.Visual inspection evidenced that the residents were provided with adequate natural light, safe ventilation, and an environment that was maintained at a safe and comfortable temperature.  |
| Standard 3.1: Infection control managementThere 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 | A managed environment that minimised the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme exists at Oakland Lifecare. The organisation’s infection control programme established, reviewed, maintained and monitored infection control policies, procedures and practices. The programme included actions required by staff, residents and visitors when exposed to infectious diseases. It was the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Familiarity and compliance with the programme was verified through interviews, observations and documentation. It was the responsibility of the infection control nurse to ensure appropriate resources were available for the effective delivery of the infection control programme and to implement the programme.The infection control programme was reviewed annually by the clinical advisory group and was last reviewed in November 2014. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The documented infection control (IC) programme implemented was appropriate for the size and services offered by Oakland Lifecare. A position description for the role of the infection control nurse (ICN) was included in the IC programme and in the RN’s personnel file.The ICN and observation verified there were enough resources to implement the infection control programme. Training records sighted verified the ICN completed ongoing training in infection prevention and control, provided by an external provider. Implementation of the infection control programme was evidenced through review of data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and in-service education records of infection control training for staff. Any IC concerns were reported at the monthly quality, health and safety and staff meetings. IC data was collected monthly and statistics and data were graphed and analysed. |
| Standard 3.3: Policies and proceduresDocumented 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 | Policies and procedure were reflective of current accepted good practice. They covered all aspects of infection control management including the correct use of personal protective clothing/equipment. The service had an IC programme that was reviewed annually at organisational level and includes compliance with policies and procedures. These policies were appropriate to the services offered by the facility. Policies were current and signed off by the clinical advisory group. Seven clinical staff interviewed described the requirements of standard precautions and could say where the IC policies and procedures were for staff to consult. Cleaning, laundry and kitchen staffs were observed to be compliant with generalised infection control practices. A staff member verified training in IC during orientation. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff received orientation and ongoing education in infection control and prevention as verified by staff training records and interviews with staff. The content of the training was documented and evaluated to ensure the content was relevant and understood. A record of attendance was maintained. Audits were undertaken to assess compliance with expectation.Education for residents occurred in a manner that recognised and met the residents’ and the families’ communication style, as verified by residents and family interviews. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | In line with Oakland Lifecare’s IC policy, procedures and programme, monthly surveillance was occurring. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month were recorded on an infection report form and graphed. Incidents of infections were sighted and rates were noted to be low. This infection data was collated each month and analysed to identify any significant trends or possible causative factors. Incidents of infections were presented at the quality, health and safety and staff meetings every month. A yearly comparison based on previous incidents was used as a comparison to analyse trends. Any actions required were presented to staff at staff meetings and any necessary corrective actions discussed, as evidenced by meeting records, IC records and verified by staff interviews. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service had overarching risk and quality management systems in place that demonstrated compliance with the restraint minimisation and safe practice (RMSP) standard. The definition of restraint and an enabler was congruent with the definition in the Standards. The process of assessment and evaluation of enabler use was recorded. Documented systems were in place to ensure the use of restraint is actively minimised.Staff interviewed and staff records evidenced guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques. Challenging behaviour, de-escalation and restraint education and training was provided for all staff during the compulsory study days during 2014. Staff competency registers record restraint competencies were current for all clinical staff. |
| Standard 2.2.1: Restraint approval and processesServices maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.  | FA | Oakland Lifecare had systems in place for determining the restraint approval processes. Staff interviewed and the residents' files sampled evidenced responsibilities were identified and known. The residents' files reviewed evidenced residents and /or family input into the restraint approval processes. There was a documented, formal process for the approval of specific restraint processes at the policy/procedure level. The restraint coordinator position was delegated to suitably skilled and experienced service provider, the clinical services manager/RN. Interview with the restraint coordinator was conducted. Clinical staff interviewed were aware of the restraint coordinator’s responsibilities. Policy/procedures define approved restraints and alternatives to restraint. There were policies relating to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement. The orientation/induction programme includes overview of RMSP policies/procedures.  |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Systems were in place that ensured assessments of residents were undertaken prior to restraint usage being implemented. The residents' files reviewed demonstrated restraint assessment and risk processes were being followed. The policies related to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement.The residents' files reviewed evidenced restraint assessment risks were documented and evaluated on a regular basis and included resident and/or family input. The multidisciplinary reviews evidenced restraint assessment risks were reviewed. Clinical staff interviewed demonstrated a sound knowledge concerning restraint procedures. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | Appropriate systems were in place to ensure the service was using restraint safely. The restraint policies and procedures identified risk processes that were followed when a resident was being restrained. The residents' files reviewed evidenced evaluations / review of restraint goals / interventions and were current. The residents' files demonstrated appropriate alternative interventions were implemented and de-escalation attempted prior to initiating restraint. The restraint consents by resident and/or family were current. The residents' files evidenced the details of the reasons for initiating the restraint, alternative interventions attempted or considered prior to the use of restraint, any advocacy/support offered, provided, or facilitated. The service provider's documentation evidenced a restraint register was established that records sufficient information to provide an auditable record of restraint use.  |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | The restraint evaluation processes were documented in the restraint minimisation and safe practice policy. The residents' files evidenced that each episode of restraint was monitored and evaluated based on the risk of the restraint used. The residents' files demonstrated residents' care plan evaluations and multidisciplinary meetings were current. Evaluation of restraint was completed every three months. Restraint meetings minutes were reviewed and were held three monthly. The clinical services manager and RNs were responsible for evaluating restraint use and this was confirmed during interview. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint reviews were completed at least three monthly. The outcome of the reviews were documented and reported on, as well as being discussed at meetings. The RMSP policies and procedures included monitoring and quality review processes. The last restraint audit was completed in May 2014 with 100% compliance. |

# 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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# 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.