# Oceania Care Company Limited - The Oaks Lifestyle Care & Village

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** The Oaks Lifestyle Care & Village

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

**Dates of audit:** Start date: 15 September 2015 End date: 16 September 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:** 90

# 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

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

The Oaks Lifestyle Care and Village is certified for 102 beds. On the day of this audit there were 90 residents who receive rest home or hospital care (44 are rest home level care and 46 hospital level care residents). There are 11 apartments and 25 studio units that can be used as assisted living, rest home or hospital care. The 102 beds are divided into two buildings.

There are areas identified at this certification audit that require improvement around medication management and care planning.

## 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. |

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, was accessible. This information is brought to the attention of residents’ and their families as part of the admission pack on admission to the facility. Residents and family members interviewed confirmed their rights were met, staff were respectful of their needs and communication was appropriate.

Residents and family interviewed confirmed consent forms are provided and they are given information they require prior to giving informed consent. Residents and family advised that time is provided if any discussions and explanation are required.

The facility manager is responsible for management of complaints and a complaints register is maintained. There has been a complaint to the Health and Disability Commissioner (HDC) which was closed at the end of August 2015.

## 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. |

Oceania Care Company is the governing body and is responsible for the service provided at The Oaks. Planning documents reviewed included an organisational strategic plan, quality and risk management plan, a business plan, a mission statement, values, and philosophy.

The business and care manager as well as the clinical manager were appointed in January 2014 and they are appropriately qualified and experienced. They are supported by a clinical quality manager and regional operations manager, who are registered nurses. The clinical manager is responsible for oversight of clinical care. Registered nurse cover is provided 24 hours a day.

There was evidence that quality improvement data is collected, collated, analysed and reported. Internal audits and satisfaction surveys are conducted and where corrective actions are required this is documented, implemented and there is evidence of completion. Risks have been identified and the hazard register is up to date. Adverse events are documented on accident and incident forms and areas requiring improvement are addressed.

There are policies and procedures on human resources management. Staff records reviewed provided evidence human resources processes have been followed. Staff education records confirmed in-service education is provided. The validation of current annual practising certificates for health professionals who required them to practice has occurred.

A documented rationale for determining staffing levels and skill mix was reviewed. The clinical manager is available after hours if required for clinical support. Care staff, residents and family reported there is adequate staff available. Resident information is 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Each stage of service provision is developed with resident and/or family input, within the required timeframes and coordinated to promote continuity of service delivery. The residents and family interviewed confirm their input into assessments, care planning and care reviews and access to a typical range of life experiences and choices.

The residents' clinical files validate service delivery to residents. Care plans are evaluated six monthly, however the evaluations require documentation of the degree of achievement towards meeting the residents’ desired outcomes. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan. Short term care plans require detailed records of interventions relating to the short term problem.

Planned activities are appropriate to the group setting. The residents confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Staff responsible for medicine management attend medication management in-service education and have current medication competencies. The resident self-administering medicines does so according to policy. Medication management system requires: three monthly medication reviews to be conducted, allergies to be recorded and as required medicines to include indication of use.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are met. There is a central kitchen and on site staff that provide the food service. The kitchen staff have completed food safety training.

## 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. |

All resident bedrooms provide single accommodation, with shared shower and toilet facilities, partial en-suites and full en-suites. Residents' rooms were observed to be of varying sizes and adequate personal space is provided. Lounges, dining areas and various other alcoves are available for residents to sit.

External areas are available for sitting and shading is provided. An appropriate call bell system is available and security systems are in place. Sluice facilities are provided and protective equipment and clothing was provided and used by staff. The service has a current building warrant of fitness.

The preventative and reactive maintenance programme includes equipment and electrical checks.

## 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. |

Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There were seven residents using restraint and twelve residents requiring enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour has been provided.

## 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 infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. The policies and procedures guide staff in all areas of infection control practice. New employees are provided with training in infection control practices and there is on-going infection control education available for all staff.

Infection control is a standard agenda item at facility’s meetings. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided.

## 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 | 48 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 0 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Staff receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code of Rights) during their induction to the service and through the annual mandatory education programme. All staff have had training on the Code. Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code was implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.  The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information. Care staff were displaying respectful attitudes towards residents and family members. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements.  The clinical manager and business and care manager reported informed consent is discussed and recorded at the time the resident is admitted to the facility. Staff interviewed demonstrated a good understanding of informed consent processes.  Residents and family interviewed confirmed they have been made aware of and understand the principles of informed consent, and confirmed informed consent information is provided to them and their choices and decisions are acted on. Residents / family are provided with various consent forms on admission for completion as appropriate and these were reviewed on resident’s files. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these were reviewed on resident’s files, where available. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The business and care manager advised the independent advocate visits the service regularly. There are appropriate policies regarding advocacy / support services in place that specify advocacy processes and how to access independent advocates.  Care staff interviewed demonstrated an understanding of how residents can access advocacy / support persons. Residents and family interviewed confirmed that advocacy support is available to them if required. They also confirmed this information is included in the information package they receive on admission. Observations provided evidence the nationwide advocate details are displayed along with advocacy information brochures. Admission information was reviewed and provided evidence advocacy, complaints and Code of Rights information is included. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The activities programme includes access to community groups and there are systems in place to ensure residents remain aware of current affairs. Residents and family members interviewed confirmed they can have access to visitors of their choice, and confirmed they are supported to access services within the community. The service has a van available to take residents on community visits. Some residents go out independently on a regular basis.  Visitors' policy and guidelines are available to ensure resident safety and well-being is not compromised by visitors to the service. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The business and care manager is responsible for complaints. The service has appropriate systems in place to manage the complaints processes. The service records complaints, the investigation of complaints, the resolutions including acknowledgement of receiving the complaint and a closing letter addressed to the complainant with a closing-out date and sign-off.  The business and care manager advised there had been a complaint investigation by the Health and Disability Commissioner which was closed out on 31 August 2015. There were no other complaints to the District Health Board (DHB), Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.  Complaints policies and procedures are compliant with Right 10 of the Code pf Rights. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. The complaint process is readily accessible and displayed.  Residents and family interviewed confirmed having an understanding and awareness of these processes. Resident meetings are held bi-monthly and residents are able to raise any issues they have during these meetings. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The Code of Rights and information on the advocacy service were available and displayed in English and Te Reo at the facility. This information is provided as part of the information packs. The admission information packs were reviewed and contain, but were not limited to, information on the Code of Rights, advocacy and complaints processes. Residents and family members interviewed confirmed they were provided with information regarding the Code of Rights and the Nationwide Health and Disability Advocacy Service prior to the resident’s admission.  Residents and family interviewed received copies of the Oceania Handbook and confirmed explanations regarding their rights occurred on admission. Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.  Residents interviewed confirmed they had access to an advocate if needed. The business and care manager advised that an advocate visits the facility on a regular basis. The completed resident and family survey questionnaires indicated residents are aware of their rights and are satisfied with this aspect of service delivery. |
| 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 | Residents were observed being treated with respect by care staff during this audit. This was confirmed during review of the completed satisfaction survey questionnaires.  Staff receive training on abuse / neglect as part of the in-service education programme. All bedrooms provide single accommodation, including the two double bedrooms. Staff were observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Care staff interviewed demonstrated an awareness of residents’ rights and the maintenance of professional boundaries.  Activities in the community are encouraged and the business and care manager advised some of the residents attend community events independently. The service encouraged different denominations to provide spiritual services to residents. Church services are held on site and some residents attend external church services. Values, beliefs and cultural aspects of care were recorded in residents’ clinical files reviewed. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The organisation has a Māori Health Plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection.  The Māori Health Plan describes that the holistic view of Māori health is to be incorporated into the delivery of services (whanau, Hinengaro, Tinana and Wairau). The rights of the residents / family to practise their own beliefs are acknowledged in the Maori health plan.  There were no residents who identify as Māori, however the service employs staff who identify as Māori when possible.  Access to Māori support and advocacy services is available if required from a local provider of health and social services. Staff members provide cultural advice and support for staff if required. A cultural assessment is completed as part of the care plan for all residents. Specific cultural needs are identified in the residents’ care plans and this was sighted in files reviewed. Staff were aware of the importance of whanau in the delivery of care for Maori residents.  Care staff interviewed demonstrated an understanding of cultural safety in relation to care. Processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education is provided as part of the in-service education programme. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Documentation provided evidence that appropriate culturally safe practices were implemented and maintained. This included respect for residents' cultural and spiritual values and beliefs. Documentation lists the details on how to access appropriate expertise including cultural specialists and interpreters.  Residents' files demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whanau contact details. Residents have a cultural assessment completed as part of the care planning process, however there were no residents identifying as Māori at the time of the audit.  Residents interviewed confirmed their culture, values and beliefs are being respected, and their spiritual needs are met. During interview care staff demonstrated an understanding of cultural safety in relation to care and confirmed that processes are in place for residents to have access to appropriate services, ensuring their cultural and spiritual values and beliefs are respected. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policies and procedures outline the safeguards to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies and procedures and staff files reviewed included copies of code of conduct that all staff are required to adhere to.  These documents address any conflict of interest issues including the accepting of gifts and personal transactions with residents and are reviewed. Expected staff practice is outlined in job descriptions and employment contracts, which were reviewed on staff files.  The business and care manager described the process for managing residents’ funds. A review of the accident / incident reporting system, complaints register and interview of the business and care manager indicates there have been no allegations made by residents of unacceptable behaviour by staff members.  Residents and family interviewed reported that staff maintain appropriate professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Systems are in place to ensure staff receive a range of opportunities which promote good practice within the facility. Documentation reviewed provided evidence that policies and procedures are based on evidence-based rationales.  Education is provided by specialist educators as part of the in-service education programme which is overseen by the clinical manager. The District Health Board (DHB) also provides education as part of the in-service education programme.  The clinical quality manager, the business and care manager and the clinical manager / registered nurse described the process for ensuring service provision is based on best practice, including access to education by specialist educators.  Staff interviewed confirmed an understanding of professional boundaries and practice. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed provided evidence that communication with family members was being documented in residents' records. There was evidence of communication with the GP and family following adverse events, which was recorded on the accident/incident forms, on family communication sheets and in the individual resident's files.  The business and care manager advised access to interpreter services is available if required via the District Health Board if required. They also advised there were no residents who required interpreter services. Residents and family interviewed confirmed that care staff communicate well with them. Residents interviewed confirmed that they are aware of the staff that are responsible for their care.  Admission agreements were reviewed and this was clearly communicated in each agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Oceania Care Company Limited’s vision, values, mission statement and philosophy are displayed at the entrance to the facility. The organisation has systems in place recording the scope, direction and goals of the organisation. The business and care manager and the clinical manager provide monthly reports to the support office relating to governance through the Oceania intranet. Governance reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators, sighted. The business and care manager’s performance objectives for the facility were sighted.  The business and care manager has been in this position for 20 months and is supported in the role by a clinical manager / registered nurse (RN), the clinical and quality manager and the regional operations manager. The business and care manager completed induction and orientation into the role. The business and care manager completed a post graduate diploma of business studies and their past experience includes senior leadership roles within the banking sector.  The clinical manager / RN is employed in a full time position to work with the business and care manager and has responsibility for the management of compliance with all clinical matters. The clinical manager worked as a clinical nurse specialist prior to commencing employment in aged care. All staff requiring practising certificates have current practising certificates. |
| 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 | The service has contracts with Christchurch District Heath Board (CDHB) for aged related residential care for hospital services (medical and geriatric) and rest home services; aged related residential respite care and support care end-of-life support (EOL) and support care severe medical illness support, long term support-chronic health conditions and residential – non aged rest home and hospital.  During the absence of the business and care manager the clinical quality manager performs the role and in the absence of the clinical manager (CM), the CM of Palmgrove stands in with the assistance of a senior registered nurse (RN). |
| 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 | The service has quality and risk management systems in place including Oceania’s clinical risk management plan and quality improvement policies, sighted. Quality improvement data is collected, collated, evaluated, and analysed to identify trends. The service develops and implements corrective actions where this is required, internal audits and adverse event records which were sighted. Policies and procedures reflect current accepted good practice and reference legislative requirements. Document control policy and procedure for new or reviewed documents is recorded and implemented.  Meetings and internal training and education sessions are conducted according to their in-service education and training programme and meeting schedules. The quality improvement and staff meetings; health and safety committee meetings, infection control committee meetings and restraint committee meetings occur monthly, including the clinical meetings for registered nurses and enrolled nurses. Resident meetings occur bi- monthly, with the minutes of meetings for January to July 2015 sighted.  The internal audit schedule and completed audits were reviewed. Quality and risk management data and quality improvement data is reported and discussed at the facility’s meetings, with meeting minutes reviewed; March to August 2015.  The health and safety manual documents health and safety management systems. This included a health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements emergency plan. Hazard registers and meeting minutes were sighted. The service completed a residents and family satisfaction survey in May 2015. |
| 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 service has an adverse event reporting system recording and reporting accidents and incidents on the Oceania intranet as part of their monthly clinical indicator reports. The system includes records of accidents and incidents relating to challenging behaviour, injuries, absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse.  Resident file reviews showed evidence of communication with families following adverse events, or when there were changes in resident’s condition. Sentinel events were recorded, investigated and corrective actions implemented, with sentinel events for April to August 2015 reviewed.  The clinical manager and business and care manager are responsible for essential notification to authorities. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are policies and procedures in relation to human resource management.  There is a planned and documented staff in-service education plan and staff attendance records are maintained, as sighted for 2014 and 2015. The training programme caters for all of the roles within the organisation and is part of the Oceania Career Pathway Programme (CPP). There is an Oceania training planner that maps out courses and dates that staff can book into and is used with clinical in-service sessions provided at the facility.  Annual practising certificates are current for all staff that require them to practice, including the clinical manager, 13 registered nurses, two enrolled nurses and 12 health care assistants.  An orientation / induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff interviews confirm orientation / induction is provided for new staff. Performance reviews are current, as reviewed in staff files. Staff files adhered to legislative requirements for human resource practices. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There are documented staffing rationale policies for determining staffing levels and skill mixes. Staff who require registration to practice have current annual practising certificates issued by the relevant responsible authorities. There is one clinical manager /RN, 13 registered nurses (RNs), two enrolled nurses (ENs) and 12 health care assistants who administer medicines and complete competencies for medicines management. Clinical staff interviews confirm staff are able to get through their work.  Residents interviewed state the care they receive is appropriate to their needs.  Rosters evidence the business and care manager and the clinical manager (RN) work Monday to Friday and are on call after hours. There is registered nurse cover 24/7, as sighted in the staff rosters. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Resident information is entered in an accurate and timely manner into a register on the day of admission. Resident files are integrated and recent information is located in the residents' files. Approved abbreviations are listed. Resident files reviewed provided evidence that an entry into the residents’ clinical record includes the time of entry, the date with entries dated and legible.  Residents' information is stored in staff areas and is held securely and is not on public display. Clinical notes were current and accessible to all clinical staff. The resident's national health index (NHI) number, name, date of birth and GP are used as the unique identifier.  Clinical staff interviewed confirm they know how to maintain confidentiality of resident information. Archived files are stored on-site for a year and then stored in the organisations’ long term storage facility, off-site. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Entry and assessment processes are recorded and implemented. The facility information pack is available for residents and their family and contains all relevant information.  The residents’ admission agreements evidence resident and /or family and facility representative sign off. The admission agreement defines the scope of the service and includes all contractual requirements. The needs assessments are completed for rest home and hospital levels of care. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is appropriate communication between families and other providers, that demonstrate transition, exit, discharge or transfer. Pans are communicated, when required |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Medication areas, including controlled drug storage areas evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug registers are maintained and evidence weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded.  All staff authorised to administer medicines have current competencies. The medication rounds were observed and evidenced the staff members were knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.  There was one resident self-administering medicines at the facility and this was conducted according to policy. The medication charts require to be reviewed three monthly, allergies to be recorded and as required medicines to be charted correctly. |
| 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 service policies and procedures are appropriate to the service setting with a seasonal menu reviewed by a dietitian.  In interview, the kitchen manager confirmed they are aware of the residents’ individual dietary needs. The residents' dietary requirements are identified, documented and reviewed on a regular basis. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change.  The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service, reported their individual preferences are met and adequate food and fluids are provided.  The food temperatures are recorded as are the fridge, chiller and freezer temperatures. All decanted food is dated. Kitchen staff have completed food safety training.  The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian’s documented assessment of the planned menu (July 2015). |
| 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 | Management interviews confirm that a process to inform residents and family, in an appropriate manner, of the reasons why the service had been declined would be implemented, if required. The residents would be declined entry if not within the scope of the service or if a bed was not available. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The residents' needs, outcomes and goals are identified via the assessment process and recorded. The facility has processes in place to seek information from a range of sources, for example: family; GP; specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.  The residents' files evidence residents' discharge/transfer information from the district health board (DHB), where required. The facility has appropriate resources and equipment, confirmed at staff interviews. Assessments are conducted in a safe and appropriate setting including visits from the doctor. In interviews, residents and family confirm their involvement in assessments, care planning, review, treatment and evaluations of care. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The residents’ care plans are individualised, integrated and up to date. The care plan interventions reflect the risk assessments and the level of care required. Short term care plans are developed, when required and signed off by the RN when problems are resolved (refer to criterion 1.3.8.2). In interviews, staff reported they receive adequate information for continuity of residents’ care. The residents and family have input into care planning and review. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interviews. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The residents' long term care plans evidence interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records are current. In interviews, residents and family confirmed their and their relatives’ current care and treatments meet their needs. Family communication is recorded in the residents’ files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | In interview, the activities coordinator confirmed the activities programme meets the needs of the service group and the service has appropriate equipment. The activities staff plan, implement and evaluate the activities programme. There is one activities programme for the rest home and hospital residents.  Regular exercises and outings are provided for those residents able to partake. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. There are current, individualised activities care plans in residents’ files. The residents’ activities attendance records are maintained. The residents’ meeting minutes evidence residents’ involvement and consultation of the planned activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Time frames in relation to care planning evaluations are documented. The residents' care plans are up-to-date and reviewed six monthly. There is evidence of resident, family, health care assistants, activities staff, allied health staff and GP input in care plan evaluations and multidisciplinary reviews. In interviews, residents and family confirm their participation in care plan evaluations and multidisciplinary reviews. Evaluations of care plans require the degree of achievement to be recorded.  The residents’ progress records are entered on each shift. When resident’s progress is different than expected, the RN contacts the GP, as required. Short term care plans as sighted in some of the residents’ files, are used when required. Short term care plans are developed for acute problems, however they require more detailed interventions to be recorded. The family are notified of any changes in resident's condition, as confirmed at family interviews.  There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Appropriate processes are in place to provide choices for residents in accessing or referring to other health and/or disability services. Family communication sheets confirm family involvement. An effective multidisciplinary team approach is maintained and progress notes detail relevant processes are implemented |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes are in place for the management of waste and hazardous substances including specifying labelling requirements. Material safety data sheets provided by the chemical representative were available and accessible for staff. Education on chemical safety was provided as part of the staff in-service education programme. Staff interviewed reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.  Observations provided evidence hazardous substances were correctly labelled, the container was appropriate for the contents including container type, strength and type of lid/opening. Sluice facilities are provided for the disposal of waste. Protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substances being handled were provided and being used by staff. |
| 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 advised that external contractors are used for plumbing, electrical and other specialist areas. During interview the maintenance person confirmed there is a maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems are in place and documentation to support this was reviewed.  Calibration reports for medical equipment were reviewed along with current electrical safety tags on electrical items. Documentation and observations evidenced a current Building Warrant of Fitness is displayed that expires 1 July 2016. Observations of the facility provided evidence of safe storage of medical equipment. Corridors are narrow in parts but residents were observed safely passing each other. Safety rails are secure and are appropriately located.  External areas are available for residents and these are maintained to an adequate standard and are appropriate to the resident group. Residents are protected from risks associated with being outside including provision of adequate and appropriate seating and shade; and ensuring a safe area is available for recreation or evacuation purposes.  Care staff confirmed they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.  Residents confirmed they know the processes to follow if any repairs /maintenance are required and that requests are appropriately actioned. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All bedrooms have wash hand basins. All resident bedrooms provide single accommodation, two rooms have shared bathroom facilities, the rest of the rooms have partial and full en-suite facilities. There are an adequate number of accessible communal showers, toilets and wash hand basins for residents. Toilets and showers are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are maintained at a safe temperature. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There are two double bedrooms that are used by individual residents. Bedrooms are personalised to varying degrees. Bedrooms are of various sizes and adequate personal space is provided in bedrooms to allow residents and staff to move around safely. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Adequate access is provided to the lounges, sitting areas and dining room. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals.  All linen is washed off-site accept for towels. Residents’ personal laundry is washed on-site. The service has well sign-posted 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.  The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner was interviewed and described cleaning processes.  Observations provided evidence that: safe and secure storage areas are available and staff have 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 (for example sluice facilities), convenient hand washing facilities are available, and hygiene standards are maintained in storage areas).  Residents and family interviewed stated they were satisfied with the cleaning and laundry service and this finding was confirmed during review of the satisfaction survey questionnaires. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification are available. Policy / procedures for the safe and appropriate management of unwanted and/or restricted visitors are available.  A New Zealand Fire Service letter dated 19 January 2005 was reviewed and confirms the fire evacuation scheme was approved on 7 March 1996. Trial evacuations are six-monthly and the most recent trial evacuation was held on 18 March 2015.  There is at least one staff member on duty with a current first aid certificate. Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for their emergency plan.  Observations provided evidence that: information in relation to emergency and security situations is readily available / displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. Observations evidenced emergency generator, emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply, blankets, and cell phones.  There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond 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 | Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family interviewed confirmed the facility is maintained at an appropriate temperature.  Observations evidenced that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control (IC) policy and procedures provide information and resources to inform staff on infection prevention and control.  The delegation of infection control matters is documented in policies, along with an infection control nurse’s (ICN) job description. The infection control nurse is the clinical manager/ registered nurse. There is evidence of regular reports on infection related issues and these are communicated to staff and management. The IC programme is reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICN has access to relevant and current information which is appropriate to the size and complexity of the service, including but not limited to: IC manual; internet; access to experts; and education. The IC is an agenda item at the facility’s meetings, evidenced during review of meeting minutes and interviews with staff. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The IC policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interviews. The IC policies and procedures are developed and reviewed regularly in consultation and input from relevant staff, and external specialists. IC policies and procedures identify links to other documentation in the facility. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control education is provided to all staff, as part of their orientation and as part of the on-going in-service education programme. In interviews, staff advised that clinical staff identify situations where IC education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted. The IC staff education is provided by the ICN and the RNs. Education sessions have evidence of staff attendance/ participation and content of the presentations. Staff are required to complete IC competencies, sighted in staff files and confirmed at staff interviews. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control nurse is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at facility’s meetings.  The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents’ files evidence the residents’ who are diagnosed with an infection have a short term care plan.  In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RN's, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents’ files.  In interview, the ICN confirmed an outbreak occurred at the facility since last audit, was reported to authorities and managed appropriately. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There were seven residents using enablers and twelve residents using restraint at the facility on audit days. The restraint and enabler use is documented in residents’ care plans.  The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.  The annual meeting of the Oceania national restraint authority group minutes record the reduction in restraint across the facilities since benchmarking commenced in 2012. |
| Standard 2.2.1: Restraint approval and processes  Services 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 | The Oceania national restraint authority group defines the approval of the types of restraints used within the organisation and this is recorded in the restraint minimisation and safe practice policies and procedures. The restraint coordinator is the clinical manager. The restraint processes and restraint approval is defined in the policies and procedures.  In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training was provided. The staff restraint competencies are current. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment prior to commencement of any restraint is conducted and recorded. Restraint assessments include: identification of restraint related risks; underlying causes for behaviour that requires restraint; existing advanced directives; past history of restraint use; history of abuse and or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Strategies are implemented prior to the use of restraint to prevent the resident from incurring injury for example: the use of low beds; mattresses and sensor mats. Restraint consents are signed by appropriate staff and family/ resident.  The restraint register is up to date and records all necessary information. Restraint is monitored by the clinical manager/ restraint coordinator monthly and reported to Oceania support office as a clinical indicator.  Health care assistants are responsible for monitoring and completing restraint forms when the restraints are in use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Each episode of restraint is evaluated. Restraints are recorded in the residents’ care plans and reviewed along with the care plan reviews. Additionally, the need for continuing individual resident’s restraint use is reviewed bi-monthly at the restraint meetings.  The resident (if able) and the family are involved in the evaluation of the restraints’ effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Oceania national restraint authority group meeting was conducted in February 2015. The meeting minutes record: the approval of types of restraint; extent of restraint use; trends identified across Oceania Health care facilities; progress in reducing restraint nationally; adverse outcomes from restraint interventions; staff compliance with restraint programme policies and protocols; and restraint practices and staff knowledge and competency in relation to restraint.  There is evidence of monitoring and quality review of the use of restraints at the facility. The restraint meetings occur bi-monthly at the facility and evidence review of all restraint and enabler use. |

# 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 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Medicine charts evidence residents' photo identification, legibility and discontinued medicines are dated and signed by the GPs. The residents' medicine charts record all medications a resident is taking (including name, dose, frequency and route to be given).  Three monthly medication reviews were not current in 15 of 30 medication chart reviews. Allergies were not recorded in four of thirty medication charts, however the clinical manager ensured this was completed on days of audit. As required medications (PRN) did not include indication of use in 19 of 30 medication charts reviewed. | Three monthly medication reviews, documentation of allergies and correct prescribing of PRN medications are not consistently conducted as required. | Provide evidence three monthly medication reviews are conducted, allergies are recorded and as required medicines are prescribed correctly.  90 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Short term care plans are recorded for short term problems, however the required interventions are not consistently documented. Care plan evaluation are conducted six monthly, however do not consistently record the degree of achievement. Multidisciplinary reviews are current. | i) Short term care plans do not consistently record the required interventions for short term problems.  ii) Evaluations of care plans do not consistently record the degree of achievement to the interventions and progress towards meeting the resident’s outcomes. | Provide evidence the short term care plans document the required interventions and the evaluations of care plan record the degree of achievement towards outcomes.  90 days |

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

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

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

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

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End of the report.