Olive Tree Holdings Limited

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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.

The specifics of this audit included:

Legal entity:	Olive Tree Holdings Limited
Premises audited:	Olive Tree Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 14 June 2016 End date: 14 June 2016
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	43

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

Indicator	Description	Definition
	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

Olive Tree rest home and dementia care retirement village is part of the Arvida aged residential care group.

An experienced village manager is responsible for the daily operations of the service. A clinical services manager/registered nurse support her. The service provides rest home and dementia level of care for up to 46 residents. On the day of the audit there were 43 residents including four rest home residents in apartments.

The residents and relatives spoke positively about the care and services provided at Olive Tree rest home.

This surveillance audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

The service has addressed one of one finding from the previous certification audit around progress notes and general practitioner records.

This audit identified an area for improvement around wound care documentation and dating of eye drops in use.

Consumer rights

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

Residents and family interviewed verified that management has an open door policy. The service communicates appropriately with residents and families. Complaints processes are implemented and managed in-line with the Code.

Organisational management

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

Olive Tree is part of the Arvida group. A team at head office provides support for management. The service is implementing a quality and risk management system that supports the provision of clinical care. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys.

There are human resources policies including recruitment, job descriptions, selection, orientation, and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

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

The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans, and reviews residents' needs, outcomes and goals with resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly.

The activities programme meets the individual recreational, physical, cultural and cognitive abilities and preferences of the residents.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for administration of medicines and complete annual education and medication competencies.

Food, fluid, and nutritional needs of residents are provided in-line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritious snacks available 24 hours in the dementia unit.

Safe and appropriate environment

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

The building holds a current warrant of fitness.

Restraint minimisation and safe practice

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

Restraint minimisation is practiced and overseen by the registered nurse. There are no residents using enablers or restraints.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. Surveillance data is collected and collated.

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	15	0	2	0	0	0
Criteria	0	38	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice, which aligns with Right 10 of the Code. Complaints forms are visible and available for relatives/residents. A complaints procedure is provided to residents within the information pack at entry. The complaints file was reviewed and there is an up-to-date complaints register. Five complaints from 2016 were reviewed. This included both verbal and written complaints and they all show that appropriate and timely responses have been documented. One complaint was sent through the Health and Disability Advocacy service and was a follow-up complaint from an earlier complaint around meal services. This has been responded to and the service awaits a reply.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. The manager and registered nurse confirm family are kept informed. Relatives (one rest home and one dementia care) stated they are notified promptly of any incidents/accidents. Resident meetings are held monthly. Care plans reviewed include the resident and or family signatures and ten resident related incident forms reviewed all include family notification of the incident. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Olive Tree is part of the Arvida group. It is currently certified to provide rest home and dementia level care for up to 46 residents, including up to five rest home residents in the serviced apartments. On the day of audit, there were 26 rest home level residents including four residents in serviced apartments, and 16 dementia level residents. There were no respite residents and all residents were on the ARC contract. The service has a mission statement and philosophy. A village manager who has many years' experience in aged care manages the facility. A clinical services manager (registered nurse), who has worked with the service as an RN for three years, has been clinical services manager for seven months. The managers have completed at least eight hours of professional development including regional provider meetings.
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	Olive Tree has a quality and risk programme that is being implemented. There is a documented business plan 2016 to 2017, as well as a quality and risk plan. The service is in the process of linking to the Arvida corporate process, such as business and quality plan templates and implementing the Arvida policies and procedures. The facility has reviewed services and has documented action plans for areas for improvement. These included an improved laundry process, the creation of a team leader on the dementia unit to improve continuity of care, individualisation of doors in the dementia unit to assist resident's recognition of their own room, music therapy, a dementia support group and a weight project to reduce weight loss. All action plans are documented and evidence follow-up to ensure the projects continue to improve services. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies. Assessment policies have been updated to include reference to the use of the InterRAI assessment tool. The service collects and collates accident/incident and infection control data. Monthly comparisons include trends and graphs. A robust quality process is in place that includes a monthly internal audit schedule, and collection and collation of incidents and accidents. The service has reviewed quality outcomes and implemented a variety of quality plans. The quality plans are evaluated regularly. Staff interviewed are aware of quality outcomes and the quality plans. Staff meetings are held. An internal audit programme covers all aspects of the service and aligns with the requirements of the Health

		and Disability Services (Safety) Act 2001. Corrective actions are developed, implemented and signed off.
		There is an implemented Health and Safety, and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirm they are kept informed on health and safety matters at meetings.
		There is a falls prevention and management policy in place and falls are addressed on an individual basis as part of the care planning process.
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	Ten falls related accident/incident forms for the month of May 2016 were sampled. Registered nurses document clinical reviews following incidents and accidents. Accidents/incidents were also recorded in the resident progress notes and changes to care plan documented as needed (link 1.3.6.1). There is documented evidence the family had been notified promptly of accidents/incidents. The service collects incident and accident data and analyses falls according to the time of the fall. Monthly collation includes graphs and trend analysis. A report is generated for the senior management team that includes frequent fallers, and comparison of all incident rates with the previous months (link to 1.2.3 6 for communication through meetings). Discussions with the manager confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications.
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 human resources policies to support recruitment practices. Five staff files sampled (one RN, one cook and three caregivers) contained all relevant employment documentation. Current practising certificates were sighted for the registered nurses. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed that new staff were adequately orientated to the service on employment. An education planner is in place that covers compulsory education requirements over a two-year period. The RNs have completed InterRAI training. Clinical staff complete competencies relevant to their role. Caregivers who work in the dementia unit are sufficiently qualified and meet the ARC contract requirements.
Standard 1.2.8: Service Provider Availability Consumers receive	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The manager and clinical services manager (RN) are on-site full time and available afterhours. There is at least one

timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		RN on duty every day as well as the clinical manager. The caregivers, residents and family interviewed advised that there are sufficient staff on duty at all times.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Care staff maintain progress notes that record a residents care and any significant events. All entries are dated, timed and signed with designation. The previous finding around time of entries has been addressed. Medical notes are legible, including the medical practitioner signature. Medication charts are on an electronic medication system. The previous finding around identification of the medical practitioner has also been addressed.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses and caregivers who administer medications, have been assessed for competency on an annual basis and attend annual medication education. Registered nurses have completed syringe driver training. The service uses an electronic medication system. All medications are checked on delivery against the medication chart. Medication fridges are checked weekly and are maintained within the acceptable temperature range. There were undated eye drops in the rest home and dementia care medication trolleys. Standing orders are not used. There was one self-medicating rest home resident with a self-medication competency that had been reviewed three monthly. Self-medication monitoring is evident in the electronic medication system. Ten medication charts (six rest home and four dementia-care) were reviewed. All medication charts had photo identification and allergy status documented on the chart. The administration signing sheets corresponded with the medication charts. All medication charts had been reviewed at least three monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this	FA	All meals at Olive Tree are prepared and cooked, by qualified cooks on-site. The cooks are supported by morning and afternoon kitchenhands. Food services staff have attended basic food safety training. A dietitian has reviewed the seasonal menu. Meals are served directly from the kitchen to the resident dining area. Meals are delivered in a bain-marie to the apartments. Plated meals are delivered in hot boxes to the dementia care unit. The cook receives a resident dietary profile for new residents and notified of any dietary changes. Likes and dislikes are known. Special diets are accommodated including high protein, high calorie, diabetic desserts,

service is a component of service delivery.		low sodium and vegetarian. There are nutritious snacks available 24-hours in the dementia care unit. Fridge and freezer temperatures are taken and recorded twice daily. End cooked food temperatures are recorded. Perishable foods sighted in the fridges were dated. Chemicals are stored safely. A maintenance and cleaning schedule is maintained. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. There is documented evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits, referrals and changes in medications. Discussions with families and notifications are documented on the 'communication with family' form in the resident files reviewed. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms and ongoing evaluation forms were in place for three residents with wounds. Not all wound care documentation was in place. The service has access to a wound nurse specialist if required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, and pain, challenging behaviour, food and fluid input charts. Post falls documentation was incomplete for one resident. Short-term care plans document appropriate interventions to manage short-term changes in health.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their	FA	The service employs two qualified diversional therapists (DT) who both work 30 hours per week each in the rest home and the dementia care unit. Both work Monday to Friday with an activity person for 2.5 hours in the weekends. Caregivers also initiate activities such as movies, small group activities and one-on-one activities for residents, in the weekends. The DTs provide individual and group activities for rest home and dementia care residents that meet the abilities and preferences of the residents. There are separate programmes for each area with integrated activities for entertainers, church services and happy hours. The DT hobby room is utilised for baking, craft and art therapy. Volunteers are involved in the activity programme with canine therapy, music

needs, age, culture, and the setting of the service.		and church services. Residents are encouraged to maintain community links, including attending social and community events. Van outings are regularly offered for rest home and dementia care residents. Family support group meetings are held and families are invited to attend the monthly resident meetings. A diversional therapy resident social profile is completed on admission. Individual activity plans were sighted in the resident files. The DTs are involved in the six-monthly multidisciplinary review. The service receives feedback and suggestions for the programme through surveys and resident meetings.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The RN evaluated all initial care plans (sampled) within three weeks of admission. The multidisciplinary team has reviewed long-term care plans at least six monthly or earlier for any health changes. Family are invited to attend the MDT review and are informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated, documented within the progress notes, and are evident in changes made to care plans.
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 facility has a current building warrant of fitness that expires on 31 July 2016.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinators collate information obtained through surveillance, to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information is on display for staff (link 1.2.3.6). Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collected and collated. Annual infection control reports are completed. Trends are identified and preventative measures put in place. There have been no outbreaks.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint minimisation is practiced. The registered nurse oversees the restraint process within the facility. There are policies around restraint, enablers and the management of residents who may exhibit behaviours that challenge. The service currently has no residents using enablers or restraints. Any resident requiring restraint, or who exhibited behaviours that may challenge would be reassessed to determine their suitability to continue to reside in the rest home.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.1 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 Low	All medications were stored correctly. There were no expired medications. Two eye drops in the rest home medication trolley had been dated on opening.	Four out of six eye drops in use in the rest home medication trolley had not been dated on opening. One eye drops in use in the dementia care unit had not been dated on opening.	Ensure all eye drops are dated on opening. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	There were three minor wounds being treated on the day of audit. One wound had a wound assessment and short-term care plan in place. One rest home resident identified as a high falls risk had accident/incident forms completed post falls but a shortfall was	1) One resident's wound did not have a wound assessment or short-term care plan in place. Another wound did not have a short-term care plan completed. 2) A frequent-falls analysis and post falls assessment had not been completed for one rest home	1) Ensure wound management documentation is completed for all wounds. 2) Ensure all post falls assessments are

		identified around post falls assessments as per protocol.	resident identified at high risk of falls and a frequent faller.	completed for frequent fallers and those identified at high risk of falls. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.