# Oceania Care Company Limited - Dunblane Rest Home and 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:** Dunblane Rest Home and Village

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

**Dates of audit:** Start date: 8 February 2017 End date: 9 February 2017

**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:** 59

# 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

Dunblane Rest Home and Village (Oceania Care Company Limited) can provide care for up to 75 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. Occupancy on the day of the audit was 59. The service provides rest home, hospital and dementia level care.

The audit process included the review of policies and procedures, the review of residents and staff files, and observations and interviews with residents, family, management, staff and two medical officers.

The business and care manager is responsible for the overall management of the facility and is supported by the regional and executive management team. Service delivery is monitored. There are requirements for improvement relating to service delivery meeting the required timeframes and activities in the dementia unit.

## 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, is accessible in information packs and displayed within the service. Residents and family members confirmed their rights are met, staff are respectful of their needs and communication is appropriate.

Residents, families and enduring power of attorney are provided with information required prior to giving informed consent. Time is provided if any discussions and explanation are required relating to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).

A complaints register is maintained. Complaints are managed as per timeframes in the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

## 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 Limited is the governing body and is responsible for the service provided at Dunblane Rest Home and Village. The business and care manager is qualified and experienced in management systems and processes. The business and care and clinical managers are new to their roles and are therefore supported by the clinical and quality manager (regional), the operations manager (regional) and the senior clinical and quality manager (national) regarding oversight of the service and clinical care.

Oceania Care Company Limited has a documented quality and risk management system that supports the provision of clinical care at the service. Policies are reviewed at support office and are current. Quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status reports. Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators. Resident information is identifiable, accurately recorded, current, confidential, accessible when required and securely stored.

There are human resource policies implemented around recruitment, selection, orientation, staff training and development. Staff, residents and family confirmed that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

## 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. |

The organisation works with the Needs Assessment Coordination Service to ensure access to the service is efficient with all relevant information available, whenever there is a vacancy.

The residents' needs are assessed on admission by a registered nurse using initial nursing risk assessments that serve to form the residents’ initial care plans. Nursing care plan evaluations are documented, resident-focused and indicate progress towards meeting the residents’ desired outcomes. Where the progress of a resident is different from expected, a short-term care plan is completed for short-term problems. The residents and the family members have an opportunity to contribute to assessments, care plans and evaluation of care.

The planned activities are appropriate to the group setting. The residents and families interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis. The residents in the dementia unit have 24-hour challenging behaviour management plans to ensure their behaviour is managed in an appropriate manner.

There is an appropriate medicine management system in place. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. The residents self-administering medicines do so according to policy.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines for older people. The residents’ special dietary requirements, need for feeding assistance or modified equipment are met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

## 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 building and plant comply with legislation, with a current building warrant of fitness in place. The environment is appropriate to the needs of the residents. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents are provided with accessible and safe external areas. Residents’ rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Essential emergency and security systems are in place and fire drills completed every six months. Call bells are available to all residents and are monitored monthly.

## 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. |

The service uses Oceania Care Company Limited policies and procedures for restraint minimisation and safe practice, which meet the requirements of the standard. Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The restraint coordinator confirmed that enabler use is voluntary. There were five residents using restraint and six residents using enablers on audit days.

The residents’ files reviewed demonstrated that the service focuses on de-escalation processes and restraint and enabler use is documented in residents’ care plans.

## 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 and procedures include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. New employees are provided with training in infection control practices and there is on-going infection control education available for all staff. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirmed that the surveillance programme is appropriate for the size and complexity of the services provided. The surveillance of infections is occurring according to the descriptions of the processes in the infection control programme. The surveillance data is collated, analysed and reported through all levels of the organisation, including governance. Infection control surveillance data is benchmarked against other Oceania Care Company Limited facilities.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 48 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 1 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Residents stated that they receive services that meet their needs and they receive information relative to their needs. Staff receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme.  All staff have had training in the Code during the previous 12 months and interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice including: maintaining residents' privacy; giving residents choices; encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.  The auditors noted respectful attitudes towards residents on the days of the audit. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care. Resident files identified that informed consent is obtained. Interviews with staff confirmed their understanding of informed consent processes.  Service information pack includes information regarding informed consent. The BCM and CM discuss informed consent processes with residents and their families during the admission process. The policy and procedure includes guidelines for consent for resuscitation/advance directives and resuscitation orders are completed for residents when applicable. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Resident information relating to advocacy services is available at the entrance to the facility and in information packs provided to residents and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Staff training regarding advocacy services was last provided in 2016.  The health and disability advocate visits the service, as confirmed by the management team. Family and residents confirmed that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services. Family members in the dementia unit confirmed they act as advocates for their family member and also for other residents if they identify any needs. |
| 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 service has an open visiting policy and residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families confirmed they could visit at any time and are always made to feel welcome.  Residents are encouraged to be involved in community activities and to maintain family and friend networks. 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 organisation’s complaints policy and procedures is in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved.  Evidence relating to each lodged complaint is held in the complaints folder and register. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner. Staff, residents and family confirmed they knew the complaints process.  The BCM is responsible for managing complaints and residents and family stated that these are dealt with as soon as they are identified. Residents and family members were able to describe their rights and advocacy services particularly in relation to the complaints process.  There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The business and care manager (BCM) and the clinical manager (CM) discuss the Code with residents and their family on admission. Discussion relating to the Code is also included on the agenda and discussed at the residents’ meetings.  Resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. The posters identifying residents’ rights and advocacy services are displayed in the facility in te reo Māori and English. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes dignity, respect and quality of life. The service ensures that each resident has the right to privacy and dignity. The residents’ own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room and there are areas in the facility which can be used for private meetings.  A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident.  Health care assistants report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families confirmed that residents’ privacy is respected.  The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports or on the incidents reviewed in residents’ files. Residents, staff, family and the general practitioners confirmed that there was no evidence of abuse or neglect. Staff interviewed were aware of the need to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.  Resident files reviewed confirmed that cultural and/or spiritual values and individual preferences are identified. |
| 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 cultural responsiveness policy which outlines the processes for working with people from other cultures. A Māori health plan outlines how to work with Māori and the relevance of the Treaty of Waitangi. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan.  Staff who identify as Māori are able to provide support for Māori residents and their families, if needed. Fifty percent of the staff are of Māori decent and most speak fluent te reo Māori.  A review of residents’ files confirmed that specific cultural needs are identified in the residents’ care plans. The BCM stated that a kaumātua can be accessed by the service to support staff on tikanga protocols and general advice. Staff are aware of the importance of whānau in the delivery of care for the Māori residents. |
| 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 | Staff and resident interviews confirmed there are choices for residents regarding their care and services. Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the resident’s cultural values and beliefs. The initial care plan, the long-term care plan and interRAI assessment are based on this information.  Staff are familiar with how translating and interpreting services can be accessed. Residents in the service did not require interpreting services on audit days. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility implements the Oceania Care Company Limited (Oceania) policies and procedures based on good practice, current legislation and guidelines. Interviews confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. Staff training includes discussion of the staff code of conduct and prevention of inappropriate care. There were no complaints recorded in the complaints register for the previous 12 months relating any form of discrimination.  Job descriptions include the responsibilities of position including ethical issues relevant to the role. Staff complete orientation and induction include recognition of discrimination, abuse and neglect. Staff confirmed their understanding of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service implements Oceania policies to guide practice. The policies align with the Health and Disability Services Standards.  The organisation’s quality framework includes their internal audit programme. Benchmarking occurs across all the Oceania facilities. There is a training programme for all staff and managers are encouraged to complete management training.  Residents and families expressed a high level of satisfaction with the care delivered. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/EPOA of any accident/incident that occurs.  Procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident/accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms. Family contact is recorded in residents’ files. Family confirmed that they are invited to the care planning meetings for their family member and can attend the residents’ meetings. Families confirmed they are well informed.  Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. The admission agreements reviewed were signed on the day of admission. Family of residents in the dementia unit state that they can raise any issues on behalf of their family member and believe that these are followed up promptly. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Dunblane Rest Home and Village is part of the Oceania Care Company Limited (Oceania) with the executive management team providing support to the service. Communication between the service and managers occur monthly with the clinical and quality manager providing support during the audit. The monthly business status report provides the executive management with progress against identified indicators.  The organisation’s mission statement and philosophy are displayed at the entrance to the facility. Information in booklets is given to new residents and staff training is provided annually.  The service has a business and care manager (BCM) supported by a clinical manager (CM). The BCM has been in the role for nine months and has a management background with a diploma in business management. The CM has been in the position for four months, holds a current annual practising certificate and is supported by the clinical and quality manager (CQM). The management team is well supported in their roles and have completed appropriate induction and orientation to their roles. |
| 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 | Due to the CM not being in the role long enough to stand in for the BCM, the service has a process in place that in the absence of the BCM, the CQM (regional) or the operations manager stands in. These roles are also supported by the national clinical and quality manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Dunblane Rest Home and Village uses the Oceania quality and risk management framework to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Oceania support office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hardcopy. New and revised policies are presented to staff to read and staff sign to evidence that they have read and understood the new/revised policy.  Service delivery is monitored through complaints management; review of incidents and accidents; surveillance of infections; pressure injuries; soft tissue/wounds; and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues completed. Internal audits are completed in line with the quality audit schedule, with evidence of corrective actions identified and implemented.  Monthly staff meeting minutes including quality improvement, health and safety, and infection control, evidence communication with all staff around all aspects of quality improvement and risk management. There are monthly resident meetings coordinated by the diversional therapist that keep residents informed of any changes. Staff report that they are kept informed of quality improvements. Family are invited to come to the resident meetings. The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly with a facility health check completed quarterly by the clinical and quality manager  The satisfaction survey for family and residents was completed in 2016 and reflects the satisfaction of the residents and family. |
| 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 BCM is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police attending the facility, sentinel events, infectious disease outbreaks and changes in key management roles.  Staff interviews and review of documentation evidence that staff document adverse, unplanned or untoward events on an accident/incident form which are signed off by the BCM. There have been no deaths referred to the coroner or essential notifications to Ministry of Health (MoH) and district health board (DHB) since the last audit. |
| 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 | The registered nurses hold current annual practising certificates along with other health practitioners in the service. Staff files include appointment documentation including signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal.  All staff complete an orientation programme and health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Health care assistants confirmed their role in supporting and budding new staff. A new staff member interviewed confirmed they had a comprehensive orientation programme.  Annual competencies are completed by clinical staff and evidence of completion of competencies is kept on staff files. The organisation has a mandatory education and training programme with an annual training schedule documented. Staff attendances are documented for internal training provided with some registered nurses and health care assistants attending.  Education and training hours are at least eight hours a year for each staff member. Two of the five registered nurses have interRAI training and staff have completed training around pressure injuries in 2016. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.  There are 69 staff, including the management team, clinical staff, a diversional therapist, and household staff. There is always a registered nurse on each shift. The BCM and CM are on call after hours. Residents and families confirmed staffing is adequate to meet the residents’ needs. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retains relevant and appropriate information to identify residents and track records. This includes information gathered on admission, with the involvement of the family.  There are policies and procedures in place for privacy and confidentiality. Staff described the procedures for maintaining confidentiality of resident records, relevant resident care, and support information can be accessed in a timely manner.  Entries were legible, dated and signed by the relevant health care assistant, registered nurse or other staff member, including their designation. Resident files are protected from unauthorised access by being locked away in an office.  Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual resident files demonstrated service integration. |
| 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 | The residents’ entry into services and the assessment processes are recorded and implemented. The service’s philosophy is displayed at the facility and communicated to residents, family, relevant agencies and staff. The facility information pack is available for residents and their family and contains all relevant information.  The residents' admission agreements evidenced 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, hospital and dementia level 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 | Exit, discharge or transfer is managed in a planned and coordinated manner with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the residents’ progress notes. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication areas, including controlled drug storage evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded.  All staff authorised to administer medicines have current competencies. Administration records are maintained, as are specimen signatures. Staff education in medicine management is provided.  Computerised medicine charts evidenced current residents' photo identification, legibility, as required (PRN) medication is identified for individual residents and correctly prescribed, three monthly medicine reviews are conducted 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). The residents self-administering medicines at the facility do so according to policy. |
| 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 | A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, was sighted.  The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences are met and adequate food and fluids is provided. The residents who are identified with weight loss have completed short-term care plans and relevant interventions to monitor the weight loss or gain.  The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification of compliance.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. |
| 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 | 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, confirmed at management interview. 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 DHB, where required. The facility has appropriate resources and equipment, confirmed at staff interviews. The assessments are conducted in a safe and appropriate setting including visits from the NP and the GP. In interviews, residents and family confirmed their involvement in the 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. InterRAI assessments are completed by an RN and inform the long-term care plans (refer to criterion 1.3.3.3). The short-term care plans are developed, when required, and signed off by the RN when problems are resolved. In interviews, staff reported they receive adequate information for continuity of residents’ care. The residents have input into their care planning and review. The NP and GP care is implemented, sighted in current NP and GP progress reports and confirmed at NP and GP interviews (refer to criterion 1.3.3.3). |
| 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' care plans evidence detailed interventions based on assessed needs, desired outcomes or goals of the residents. The NP and GP documentation and records are current. In interviews, residents and families confirmed their and their relatives’ current care and treatments meet their needs. Family communication is recorded in the residents’ files. The nursing progress notes and observation charts are maintained.  In interviews, staff confirmed they are familiar with the current interventions of the residents 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. | PA Low | In interviews, the diversional therapist (DT) and the activities coordinator (AC) confirmed the activities programmes meet the needs of the service group and the service has appropriate equipment. The DT and the AC plan, implement and evaluate the activities programmes. There is one activities programme for the rest home and hospital residents and one programme for residents with dementia. Along with the activities staff, the HCAs in the dementia unit implement individual residents’ activities, as recorded on the residents’ 24-hour activities care plans, however, this is not recorded when outside of the activities programme during the week.  Regular exercises and outings are provided for those residents able to partake. The activity programmes include 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 evidenced 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. | FA | Resident care is evaluated on each shift and reported in the nursing progress notes. If any change is noted it is reported to the RN.  The formal care plan evaluations, following reassessment to measure the degree of a resident’s response in relation to desired outcomes and goals do not consistently occur every six months (refer to criterion 1.3.3.3). Where progress is different from expected, a short-term care plan is initiated for short-term concerns, such as infections, wound care, changes in mobility and the resident’s general condition. Short-term care plans are reviewed daily, weekly or fortnightly, as indicated by the degree of risk noted during the assessment process. The wound care plans did not evidence timely reviews (refer to criterion 1.3.3.3). Interviews verified residents and family are included and informed of all changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Appropriate processes are in place to provide choices for residents in accessing or referring to other health and/or disability services. The family communication sheets, located in the residents’ files confirmed 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 for the management of waste and hazardous substances are in place and incidents are reported on, in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirements for labels to be clear, accessible to read and free from damage.  Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education in safe and appropriate handling of waste and hazardous substances.  There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas. Chemicals are stored in a designated shed with chemical hazard signs. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed. There have been no building modifications since the last audit, although there has been refurbishment of the facility as part of the Oceania’s facilities upgrade programme, including an upgrade to the kitchen and one of the garden court yards.  There is a planned and reactive maintenance schedule implemented. The service has an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually. Interviews with staff and observation of the facility confirmed there is adequate equipment.  There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are internal courtyards and lawns, areas with shade and outdoor table and chairs.  The secure unit for residents with dementia has one entrance with a key pad access internally and one exit into a secure courtyard. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible toilets/bathing facilities. All toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence.  Auditors observed residents being supported to access communal toilets and showers, in ways that are respectful and dignified. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Equipment was sighted in rooms requiring this with sufficient space for the equipment, staff and the resident.  Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own. There are designated areas to store mobility aids, hoists and wheelchairs. The hospital rooms and assisted care rooms are large enough to accommodate specific aids. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has lounge/dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.  The dining areas have ample space for residents. Residents can choose to have their meals in their room. The dementia unit has its own dining room and lounge area, with residents in the dementia unit encouraged to join in some activities held in the main hospital/rest home area. |
| 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 | Laundry is completed off site, and is delivered daily. Laundry is transported in appropriate colour coordinated linen bags. Laundry staff sort the personal laundry in the evening and health care assistants are required to return linen to the rooms. Residents and family members confirmed that the laundry is well managed. There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and are aware that the trolley must be with them at all times. Cleaners were observed in the dementia unit keeping the trolley in sight and limiting the chemical cleaning agents on the trolley.  All chemicals are in appropriately labelled containers. Training about the use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | An evacuation plan was approved by the New Zealand Fire Service in 2005 and again in 2015. An evacuation policy on emergency and security situations is in place. A fire drill is conducted six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. Fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.  There is always one registered nurse with a current first aid certificate on duty. A disaster management plan is in place with clear information for staff to follow in the event of an emergency. There are adequate supplies, including food, water, blankets, emergency lighting and gas BBQ.  An electronic call bell system is in place. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways and dining rooms. Call bell audits are routinely completed. Observation on the days of audit and interviews with residents and families confirmed there are prompt responses to call bells. Sensor mats are used where appropriate. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature. Families and residents confirmed that rooms are maintained at an appropriate 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 Oceania infection prevention and control (IPC) policies and procedures manual provides information and resources to inform staff on infection prevention and control. There are strategies in place to prevent exposure of infections to others, from residents, staff and visitors, who are suffering from infectious diseases.  The responsibility for infection control is clearly defined in the IPC policy that includes: responsibilities of the Oceania IC committee (company –wide); infection control nurse (ICN) and the infection control team. There is a signed ICN job description outlining responsibilities of the position. The ICN is supported in their role by the business and care manager, the clinical and quality manager, the clinical manager and the infection control team. The ICN is a registered nurse.  There is evidence of regular reports on infection related issues and these are communicated to staff, management and Oceania support office. The Oceania wide infection control programme is reviewed annually by the Oceania infection control committee (companywide). The facility’s IPC programme is reviewed by the infection control team at the facility. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICN has access to relevant and current information which is appropriate to the size and complexity of this service, including but not limited to: the infection control manual; internet; access to experts; and education. The infection control is an agenda item at the facility’s meetings, evidenced during review of meeting minutes and interviews with staff. The internal audit programme includes infection control audits to monitor the implementation of the infection control programme. |
| 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 Oceania infection control committee (company-wide) develop and review the IPC policies and procedures to be implemented within the Oceania facilities. They are developed and reviewed regularly in consultation and input from relevant staff and external specialists. The infection control manual is up to date, policies reflect current accepted good practice and relevant legislative requirements. The infection control manual is readily accessible to all personnel, confirmed at staff interviews. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control education is provided to all staff, as part of their orientation and as part of the ongoing in-service education programme. In interviews, staff advised that clinical staff identify situations where infection control education is required for a resident such as: hand hygiene and cough etiquette. One on one education is conducted. The infection control staff education is provided by the ICN. The ICN has attended external education relating to infection prevention and control. Education sessions have evidence of staff attendance/participation and content of the presentations. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The ICN 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 evidenced the residents’ who were diagnosed with an infection had a short-term care plan in place.  In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from: the CM; RNs; verbal handovers; short-term care plans and progress notes. This was observed at the staff handover and review of the residents’ files.  In interview, the Oceania clinical and quality manager confirmed an outbreak occurred in November 2015. Documentation evidences the authorities were notified of the outbreak. The facility’s surveillance data is benchmarked against other Oceania facilities and this information is shared with staff and management. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler in the Oceania wide policy is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded and implemented (refer to criterion 1.3.3.3). There were six residents at the facility using enablers and five residents using restraints on the days of the audit. The restraint and enabler use was 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.  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 is provided.  Oceania support office maintain records of restraint use and analysis is conducted monthly by the clinical and quality managers. The results indicated there has been a reduction in restraint used nationally due to the use of low/low beds and the use of perimeter mattress surrounds. |
| 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 Care Company clinical and quality team are responsible for approving any form or type of restraint practice used at Oceania facilities nationally. Oversight of restraint use at each individual Oceania facility is the responsibility of restraint coordinators. The restraint coordinator at Dunblane is the clinical manager (CM). The responsibilities for this role are defined in the position description, sighted. The restraint coordinator has completed training in restraint minimisation and restraint management relevant to their role and was able communicate their knowledge relating to the restraint minimisation standard.  Restraints are authorised following a comprehensive assessment of the resident. The approval includes consultation with other members of the multidisciplinary team. The restraint consent forms evidence consent for restraint is obtained from a GP, restraint coordinator and the resident and/or a family member. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint assessment is completed prior to commencement of any restraint. The clinical files of residents using restraint evidenced the restraint assessment authorisation and care plans are in place. Restraint assessments evidenced the restraint coordinator’s sign off and evidenced all appropriate factors have been taken into consideration. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The protocols on safe use of restraint detail the processes of assessment, approval and implementation. Protocols guide staff in the safe use of restraint. Strategies are implemented prior to the use of restraint to prevent the resident from incurring injury, for example: the use of low beds and sensor mats. The policies that guide staff in the safe use of restraint document: the current approved forms of restraint; the indications for use; associated risks; safety precautions; and required authorisation, reporting and monitoring requirements.  Staff training and education in restraint use includes appropriate orientation and ongoing education. Evidence of ongoing education regarding restraint and challenging behaviours was evident. Restraint competency testing of staff is included in the education of staff.  The restraint register is up to date and records all necessary information to provide an auditable trail of restraint events.  The health care assistants are responsible for monitoring and completing restraint forms when the restraints is in use, confirmed at interviews with staff and review of documentation. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Evaluation of restraint occurs through restraint event reporting by management to the Oceania support office through measuring relevant clinical key performance indicators. Each individual episode of restraint is evaluated. The clinical files of residents using restraint evidence the restraint evaluation forms are completed and these include all the relevant factors in this standard (refer to criterion 1.3.3.3).  The restraint minimisation team meeting minutes evidence evaluation of each restraint use at the facility.  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 | There is evidence of monitoring and quality review of the use of restraints at the facility. The restraint minimisation team meeting minutes evidenced review of the compliance with the standard and includes: individual resident’s restraint review; restraint register update; education review and any relevant restraint issues. The restraint meetings are held monthly. Audits relating to restraint use are conducted and include detailed review of residents’ clinical files of residents who use restraint.  Oceania national restraint authority group terms of reference are recorded. This group meet annually to review the compliance with the restraint standard and review of restraint use nationally. The last Oceania national restraint authority group meeting was conducted in February 2016. |

# 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 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | The initial care plans are completed on residents’ admission to the facility, however, the long-term care plans and interRAI assessments are not consistently completed within the three weeks of resident’s admission.  The GP and NP initial assessments are completed within the required timeframe, however, the follow up medical reassessments do not occur according to the DHB contract timeframes. The GP and NP exemptions are not consistently recorded for residents deemed stable to be able to be reassessed three monthly.  The pressure injury wound reassessments (three of three) did not occur within the required timeframe and one of the three pressure injury did not record measurements of wound.  The long-term care plans are not consistently evaluated/reviewed six monthly. | Clinical service delivery timeframes are not consistently adhered to. | Provide evidence the clinical service delivery timeframes are adhered to.  60 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | There are two activities programmes for the facility. One programme is planned and implemented for rest home, and hospital residents and second programme for residents in the dementia wing. The planned programmes are scheduled from Mondays through to Fridays each week and finish around 3 pm each day. There is no documented evidence activities are provided for residents with dementia in late afternoons and evenings. The weekend activities in the dementia wing provided by the HCA are recorded and residents’ participation is monitored. Interviews with the RNs, HCAs, DT and management stated the HCAs provide activities in the dementia wing in the late afternoon and evenings during the week days, however, there is no recorded evidence of this. | There is no documented evidence that the residents in the dementia wing receive activities outside of the planned activities programme timeframes during the week days. | Provide evidence of activities provided for residents with dementia outside of the planned activities programme.  180 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.