

Oxford Court Rest Home 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:	Oxford Court Lifecare Limited
Premises audited:	Oxford Court Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 March 2017 End date: 17 March 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:	48

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
Yellow	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
Red	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

Oxford Court is one of four age care facilities owned by Hurst Lifecare Limited. The service provides care for up to 50 residents at hospital (geriatric and medical) and rest home level of care with 48 residents living at the facility at the time of the audit.

This surveillance audit was conducted against aspects of the 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 residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

The service continues to be managed by an experienced general manager (GM) who is a registered nurse and has been in the role for seven years. The GM is supported by a care manager and the national quality advisor. Staff turnover is reported as low.

There are well developed systems that are structured to provide appropriate quality care for residents. Implementation is supported through the organisations quality and risk management programme that is individualised to Oxford Court. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. This audit has identified no areas requiring improvement.

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.
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A policy on open disclosure is in place. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

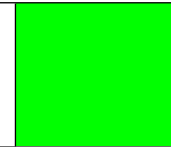
Organisational management

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.
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Quality and risk management processes continue to be well maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service and organisational goals are embedded. Corrective action plans are implemented where opportunities for improvement are identified. A robust health and safety programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided 24 hours a day, 7 days a week. There are adequate numbers of staff on duty to ensure residents are safe.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

The service has implemented an electronic system for managing all resident records. A registered nurse assesses and develops the care plan documenting support, needs, goals and outcomes with the resident and/or family/whānau input. Care plans reviewed demonstrated service integration and had been evaluated three-monthly. Resident files included review by the general practitioner, specialist and allied health services.

Two diversional therapists (in training) coordinate the activity programme for the rest home and hospital residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents are encouraged to maintain links with community groups.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for administration of medicines and complete medication competencies and annual education. The service has implemented an electronic medication system. The general practitioner reviews medications three-monthly.

Resident food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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.
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The service has a current building warrant of fitness and reactive and preventative maintenance occurs.

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.
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Oxford Court has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service maintains a restraint-free environment and no residents are currently utilising enablers.

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.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. The service benchmarks infection control data against other villages within the group.

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	16	0	0	0	0	0
Criteria	0	38	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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	A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance foyer. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There have been three complaints documented since previous audit. All complaints have been resolved. Systems and processes are in place to ensure that any complaint received is managed and resolved appropriately. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. Incidents are all documented on VCare and includes an area to identify if family are informed. A review of incident forms and progress notes identify family have been kept informed. Residents and family interviewed also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur monthly and the management team have an open-door policy. Relative's newsletters occur quarterly. A family satisfaction survey was last completed 2016 with a 95% positive outcome. An organisational analysis of family survey results in 2016 identified that Oxford Court scored the highest in relation to communication. Residents and family are advised in writing of their eligibility and

<p>conducive to effective communication.</p>		<p>the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Oxford Court Lifecare is a part of the Hurst Lifecare Limited. The service provides care for up to 50 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 48 residents in total (13 residents at rest home level and 35 residents at hospital level). All rooms are dual purpose. There was one resident under a long-term support chronic health conditions contract in the hospital and all other residents were under the Aged Residential Care (ARC) contract.</p> <p>The service is managed by an experienced general manager who is a registered nurse and has been in the role for seven years. The GM is supported by an experienced care manager.</p> <p>Hurst Lifecare Limited has an organisational philosophy, which includes a vision and values statement and objectives. The 2017 quality plan objectives include organisation objectives and facility – specific objectives for Oxford Court. Objectives are linked to the organisation’s strategies. The 2017 goal for Oxford Court includes two objectives (i) to support staff to complete NZQA qualifications relevant to their role; (ii) To ensure all RNs at Oxford Court achieve their PDRP. The 2016 quality plan objectives have been reviewed and updated (sighted). Some quality objectives from the previous year remain in place as key performance indicators across the organisation. The organisation has a strategic direction that has been communicated to staff. The service has a restorative model of care, with a focus on ‘person-centred care’. Staff interviewed could describe this approach to care.</p> <p>The general manager (GM) reports monthly to the board on a variety of management issues. The current strategic plan and quality and risk management plans have been implemented. The general manager is also supported by a national quality advisor, who arrived during the day of the audit. The general manager has maintained over eight hours annually of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management</p>	<p>FA</p>	<p>The service continues to implement a comprehensive quality and risk management system. There is increased monitoring and analysis of data collected at a facility and organisational level. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A system for document control is in place. Any new policies or changes to policy are communicated to staff, evidenced in meeting minutes and in interviews with staff. The organisation is in the process of reviewing and updating their internal audits to align with policies and procedures that have been updated. Oxford Court has implemented a number of quality initiatives since previous audit and have been piloting two quality initiatives for the organisation which include (i) implementation of medi-map and (ii) implementation of VCare. Both</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>have been successfully implemented at Oxford Court with on-going review and monitoring.</p> <p>Key components of the quality management system include (but are not limited to): monitoring falls, medication errors, restraint use, pressure areas, infections, wounds and resident satisfaction. Monthly reports submitted to the national quality advisor and the chief executive officer provide a coordinated process between service level and the organisation. There are monthly accident/incident reports that break down the data collected across rest home and hospital residents and staff incidents/accidents. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a 12-month period. Annual reports are completed at a facility and organisational level. Oxford Court 2016 annual report were sighted for risk management, medication errors, infection control, restraint, H&S and complaints. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention is a topic of the quality and staff meetings. Benchmarking and internal audit data demonstrate that Oxford Court continue to achieve good standards of care and service.</p> <p>A health and safety programme in place with strategies implemented to promote staff wellness. The health & safety committee meets as part of the quality committee monthly. In January 2017, facility again achieved tertiary status with the ACC Workplace safety management programme for a further two years. Infections and health and safety matters, such as staff accidents are discussed at the meeting and then fed back to the monthly staff meetings. Resident meetings also occur monthly. A family satisfaction survey was last completed with a 95% positive outcome. An organisational analysis of family survey results in 2016 identified that Oxford Court scored the highest in relation to communication, personnel, food, activities, communal and personal areas.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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</p>	<p>FA</p>	<p>Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and RN meetings reflect a discussion of incident stats and analysis.</p> <p>Thirteen resident related incident reports for February 2016 were reviewed on VCare. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident and where appropriate families notified.</p>

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<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (care manager, two caregivers, one RN and diversional therapist) included evidence of the recruitment process, signed employment contracts, police vetting and completed orientation programmes and annual performance appraisals. Staff turnover was reported as low.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. The general manager is currently working with Careerforce to develop their orientation programme further to align with NZQA Certificate in Health and Wellbeing. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. There are currently 19 of the 24 caregivers that have completed or in the process of completing a national caregiving qualification.</p> <p>A completed in-service calendar for 2016 exceeded eight hours annually. There is a structured education programme for all staff. Competencies (hand hygiene, chemical, fire, hoist, H&S, IC and medication) are completed annually for staff and the register identifies these are up to date. The general manager and registered nurses attend external training including conferences, seminars and education sessions with the local DHB. Seven of the current twelve RNs are interRAI trained with more scheduled for training this year.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Oxford Court Lifecare has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. All beds are dual-purpose and the roster has the flexibility to be adjusted depending on the current needs of the residents. There are at least two registered nurses on a morning and afternoon shift (one each floor) and one RN at night. In addition, the general manager (RN) and care manager (RN) also work five days a week. Extra RNs are rostered for education and completing interRAI. There are at least two caregivers on each floor each morning and afternoon shift with one caregiver rostered at night with the RN. Caregivers advise that sufficient staff are rostered on for each shift. All registered nurses have been trained in first aid and CPR.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p>	FA	<p>All medication is managed appropriately in line with required guidelines and legislation. A computerised medication management system has been implemented. Ten medication charts reviewed met legislative prescribing requirements. RNs responsible for the administering of medication complete annual medication competencies and attend annual medication education. Senior caregivers who are second checkers have annual medication competencies. The service uses individualised robotic packs for regular medications and blister packs for PRN medications. Medications are checked on delivery against the medication chart by the RN and pharmacist.</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>Medication trolley contents were all within expiry dates and all eye drops were dated on opening. There were no residents self-medicating. Medication administration practice was observed to be compliant. 'As required' medications have the date and time of administration recorded on the signing sheet.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs two cooks and four kitchen hands. There is a five-weekly seasonal menu that had been designed and reviewed by a dietitian. The cook receives a resident dietary profile for all new admissions and is notified of dietary changes as needed and/or following the three-monthly review. Specific cultural preferences were met. Resident likes, dislikes and dietary preferences were known. Food is delivered in hot boxes to each area. Staff were observed sitting with the residents when assisting them with meals. The service is well equipped. There is a food control plan in place and monitored by the Dunedin city council and the service has recently received an A grade certificate from the DCC December 2016. The chiller and freezer are monitored daily. Food temperatures are monitored twice daily and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service was received from resident and staff meetings, surveys and audits. Staff have been trained in safe food handling and chemical safety. Residents interviewed spoke positively about the meals provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. Faxes to the GPs for residents change in health status were sighted in the resident's files in the Vcare system.</p> <p>Dressing supplies are available and treatment rooms are adequately stocked for use. Wound assessment, treatment and evaluations including frequency for 11 wounds facility wide, were linked to the VCare care plans. Pressure injury prevention and interventions and updates/evaluations were documented in the long-term care plans in VCare. The RNs interviewed stated they have access to an external wound care specialist as required. The GP reviews the wounds three-monthly or earlier if required.</p> <p>Contenance products are available and resident files include a three-day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the four RN's interviewed.</p> <p>Monitoring forms in place include (but not limited to): monthly weight, blood pressure and pulse, food and fluid charts, restraint and behaviour charts. These are easily accessible in the VCare system.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>FA</p>	<p>The activities staff provide an activities programme over six days each week Monday-Saturday. There are two diversional therapists (in training), between them they work 63 hours a week. The programme is planned weekly and residents receive a personal copy of planned activities in the weekly newsletter. One of the residents prepares the word search for the newsletter. Activities planned for the day were displayed on noticeboards around the facility.</p> <p>A diversional therapy plan is developed for each individual resident, based on assessed needs. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities. The service has a van that is used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed were updated as resident's care requirements changed. Care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. The care plan reviewed for a resident who had deteriorated and was end of life was updated to reflect current needs. Short-term care requirements for residents are incorporated in the VCare long-term personal care plan and were dated and signed electronically. Care plans are evaluated within the required timeframes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness which expires on 31 August 2017. Regular and reactive maintenance occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection and monitoring also occurs of antibiotic prescribing. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections was entered on to a monthly facility infection summary and staff informed. The data has been monitored and evaluated monthly and annually at facility</p>

<p>out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>level, including benchmarking within the group and against national aged care indicators. There have been no outbreaks since previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service is committed to restraint minimisation and safe practice and this was evidenced in the restraint policy and interviews with staff and management. Restraint minimisation is overseen by a restraint coordinator who is the general manager. Restraint minimisation is discussed at quality and staff meetings. Annual review of restraint was completed in December 2016. The restraint minimisation policy includes restraint/enabler procedures. There is a documented definition of restraint and enablers which is congruent with the definition in the standard.</p> <p>The service has continued to maintain its restraint-free environment and no residents require enablers. Staff are trained in restraint minimisation and de-escalation.</p>

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.

No data to display

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, there 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.