

Oceania Care Company Limited - Eden Lifestyle Care & Village

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 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](#).

The specifics of this audit included:

| | |
|---|--|
| Legal entity: | Oceania Care Company Limited |
| Premises audited: | Eden Rest Home and Village |
| Services audited: | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 4 April 2019 End date: 5 April 2019 |
| 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: | 57 |

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

| Indicator | Description | Definition |
|---|---|--|
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |

| Indicator | Description | Definition |
|-----------|--|---|
| | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
| | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

General overview of the audit

Eden Lifestyle Care and Village (Oceania Healthcare Limited) can provide care for up to 70 residents requiring rest home or hospital level of care. There were 57 residents at that facility on the first day of the audit.

This surveillance audit was conducted against the relevant Health and Disability Service Standards and the service contract with Auckland District Health Board.

The audit process included review of policies and procedures; review of resident and staff files; and observations and interviews with family; residents; management; staff and a nurse practitioner.

There were no areas requiring improvement at the last audit and one area identified as requiring improvement at this surveillance audit relating to essential notifications.

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. |
|--|--|--|

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is provided, explained to residents and family on admission and available within the facility.

Residents, family and nurse practitioner interviews confirmed that communication is appropriate, including identification of any issues, and that staff are respectful of residents' needs.

There is a documented complaints management system and a complaints register is maintained. The business and care manager is responsible for managing complaints. Complaints are investigated and documented, with corrective actions implemented. There have been no complaints to external agencies since the last audit.

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. | | Some standards applicable to this service partially attained and of low risk. |
|---|--|---|

Oceania Healthcare Limited is the governing body responsible for the services provided at Eden Lifestyle Care and Village.

The facility is managed by an appropriately qualified and experienced business and care manager and supported by a clinical manager who is responsible for the oversight of clinical service provision. Both the business and care manager and the clinical manager are registered nurses. The facility management team is supported by the regional clinical quality manager and the regional operations manager.

The facility implements the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement. Policies are reviewed. Monthly reports to the national support office allow for the monitoring of service delivery.

Quality and risk performance is monitored through the organisation's reporting systems. Benchmarking reports include, but are not limited to: falls, infections, wounds, restraint, and complaints. An internal audit programme is implemented. Corrective action plans are documented with evidence of resolution of issues when these are identified. Staff communicate with residents and family members following any incident and this is recorded in the residents' files. There is an electronic database to record risk. Risks and controls are clearly documented.

Oceania Healthcare Limited human resource policies and procedures are implemented, and newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff who require them are validated annually. An annual training plan is implemented to ensure ongoing training and education for all staff members.

A review of rosters, service delivery staff and resident/family interviews confirmed that there is adequate staff available.

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 resident records in the rest home and hospital evidence the provider has implemented systems to assess, plan and evaluate the care needs of the residents. Care plans demonstrate residents and their family participate in the care planning processes. The residents' needs, outcomes and/or goals are identified and reviewed in the timeframes required or more frequently if required. Two records were reviewed using tracer methodology. The nurse practitioner was available for interview. The service is coordinated to promote team work and continuity of care.

Activities are coordinated and implemented in a planned and organised manner for rest home and hospital level residents. The activities programme reviewed supports the interests, needs and strengths of residents. Residents and family interviewed confirm their satisfaction with the programme.

The service has an appropriate medicine management system which is developed and implemented in line with best practice and legislative requirements. All medications are prescribed, stored and administered safely. The general practitioner/nurse practitioner reviews all medications in the timeframes required and communicates with the registered nurses and contracted pharmacy when required. Staff complete medication competencies annually. Safe practice was observed at the time of audit. Any medication errors are reported and managed appropriately. There is a review process for residents who self-administer medications.

Food services policies and procedures are reviewed and there is evidence of dietitian review and input of the winter and summer menus. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection evidences compliance with current legislation and guidelines utilised. Residents and family/whānau interviewed report satisfaction with the food service. The service has a food control plan.

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. |
|--|--|--|

There is a current building warrant of fitness. There have been no alterations to the building since the last audit.

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. |
|---|--|--|

The use of restraint is actively minimised. Staff receive education on restraint use, enablers, and the management of challenging behaviours. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain their independence and/or for safety.

Infection prevention and control

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

The infection prevention and control programme aims to prevent the spread of infection and reduce risks to residents, staff and visitors. Policies and procedures are aligned with currently accepted good practice. There is a surveillance programme which is appropriate for the size and nature of the services provided. Monthly surveillance data and audits are recorded, collated and reported to the national support office. Analysis and evaluation of data is used to develop any corrective actions required, which are monitored by the infection control coordinator in a timely manner.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 15 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 38 | 0 | 1 | 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 |
|--|-------------------|---|
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The BCM is responsible for managing complaints. An up-to-date complaint register was in place that included: the date the complaint is received; a description of the complaint; the investigation undertaken; resolution and the date the complaint is signed off. Evidence relating to each lodged complaint is held in the complaints folder and summarised on the complaints register. The complaints reviewed indicated that complaints, including verbal complaints, are investigated promptly and issues are resolved in a timely manner.</p> <p>Staff and resident interviews confirmed that the complaints process was explained to residents and family on admission. Complaint forms were made available on admission and additional forms are made available at the entrance to the facility. Residents and family interviews confirmed that they were aware of the complaints process and felt comfortable in making a complaint should they need to do so. They stated that any issues raised had been dealt with effectively and efficiently. Residents interviews confirmed an understanding of their rights to advocacy and how to access advocacy services particularly in relation to the complaints process.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner (HDC) or other external authorities since the previous audit. A previous HDC complaint was reviewed in accordance with the recommendations made and all recommendations were found to be implemented.</p> |
| Standard 1.1.9: | FA | There is a policy in place to ensure there is open disclosure of any adverse event where a resident incurred |

| | | |
|---|-----------|---|
| <p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | | <p>any unintended harm while receiving care. Completed incident forms and residents' records demonstrated that, where appropriate, family are informed if the resident has an incident/accident; a change in health or a change in needs. Family and resident interviews confirmed they are informed of any changes in the residents' health status, and that they are invited to the care planning meetings.</p> <p>Resident meetings inform residents of facility activities and provide an opportunity to: make suggestions; provide feedback; and to raise and discuss issues/concerns with management. These meetings generally occur three monthly, however, the most recent meeting minutes of the last residents' meeting was October 2018. The review of the minutes confirmed that the subjects discussed included: activities; the kitchen; security and gardening and satisfaction surveys.</p> <p>Residents and family have access to resident and family meetings minutes and are provided with copies of upcoming planned activities and menu. A newsletter provides updates on new staff; upcoming events; activities occurring around the facility such as repairs and painting; and suggestions that have been received. Family and resident interviews confirmed that the business and care manager (BCM) and staff were readily available, took time to listen and addressed any issues/concerns that had been raised promptly and effectively.</p> <p>There is policy that provides guidance and procedures for staff to ensure that residents who do not use English as their first language are offered interpreting services. It states that staff have access to a list of interpreting services and family may only interpret with a resident's consent. At the time of the on-site audit there was one resident for whom English was not their first language. Staff interviews confirmed that staff and the resident were able to communicate effectively with family members able to assist with interpretation when required.</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>Oceania Healthcare Limited (Oceania) has a documented vision, mission and values statement which is displayed in the reception at the entrance to the facility and reflects a person-centred approach to all residents. These are communicated to residents, family and staff through the use of internet and information provided to new residents and families on admission. Staff also receive this information in annual training. Oceania has documented overarching strategic goals and objectives and the facility has specific business planning objectives that are included within an annual budget specific to Eden Rest Home and Village.</p> <p>The facility is part of the Oceania group and the executive management team provide support to the facility. Communication between the facility and executive management occurs monthly with the clinical and quality manager (CQM) and another BCM providing support during the audit. The monthly reports from the facility provides the executive management team with progress against identified indicators.</p> <p>The BCM has been in the role for six months. The BCM is a registered nurse (RN) with a current practising certificate and has a bachelor's degree in business studies, a bachelor's degree in nursing and a postgraduate diploma. The BCM has previously worked as a clinical nursing director and has surgical experience. The BCM is supported by a clinical manager (CM). The CM has been working for Oceania for eight years and has been</p> |

| | | |
|--|-----------|--|
| | | <p>in the CM role at this facility for two years. The CM holds a current annual practising certificate and is supported by the Oceania CQM. The management team have completed induction and orientation appropriate to their roles.</p> <p>The facility is certified to provide rest home and hospital care with 57 beds occupied at the time of the audit. Occupancy included: 22 residents requiring rest home level care; and 33 requiring hospital level care. In addition, there was one resident for respite care at hospital level and one privately funded resident receiving rest home level care who was about to be reassessed.</p> <p>The facility has 68 care suites and is licenced for 70 residents. Residents who wish to share may do so as many of the care suites are spacious enough to be used as double rooms. There was one double room occupied by a couple at the time of audit. Fifty-one of the occupied suites have occupational right agreements (ORA) in place.</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 system that reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>The facility utilises Oceania’s documented quality and risk management framework that is available to guide staff during service delivery. Policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies are presented to staff at staff meetings and policy updates are also provided as part of the relevant in-service education. New and revised policies are made available on a notice board in the staff room. Staff interviews confirmed that they are made aware of new and updated policies. Staff interviews, and documentation reviewed demonstrated that staff sign to confirm that they have read and understood each new policy and/or update.</p> <p>Service delivery is monitored through the organisation’s reporting systems utilising a number of clinical indicators such as: complaints; falls; infections; wounds; incidents and accidents; and medication errors. There is evidence that the annual internal audit programme is implemented as scheduled. Reports evidence that quality improvement data is being collected and collated with the identification of trends and analysis of data. Where required, corrective action plans are developed, implemented, evaluated and closed out. There is communication with all staff of any subsequent changes to procedures and practice through meetings.</p> <p>Quality and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. Staff interviews reported that they are kept informed of quality improvements. There is evidence that staff sign to confirm that they attend meetings and/or have read the meeting minutes.</p> <p>Satisfaction surveys for residents and family are completed as part of the internal audit programme. Resident and family interviews confirmed satisfaction with service provision.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. There is a nominated health and safety representative. Staff interviews</p> |

| | | |
|---|--------|--|
| | | confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly. There is evidence of hazard identification forms being completed, and hazards being addressed and risks minimised. A current hazard register is available that is reviewed and updated annually or when a new hazard is identified. |
| <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 manner.</p> | PA Low | <p>The BCM is aware of situations which require the facility to report and notify statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. These are reported to the appropriate authority via Oceania support office staff. However, staff interviews and documentation review identified that not all notifiable events had been reported to the Ministry of Health (MoH). The facility had experienced a suspected scabies outbreak in 2018. Whilst not confirmed, treatment was commenced and strategies to manage this, implemented. This had been notified to the Public Health Department accordingly. A subsequent episode (recurrence) of scabies was identified and confirmed in November 2018 and notified to the Public Health Department.</p> <p>Staff interviews and review of documentation confirmed that staff document adverse, unplanned or untoward events on an accident/incident form which is signed off by the BCM.</p> <p>Staff interviews confirmed the facility provides an environment that focus on recognising and reporting errors or mistakes as opportunities for improvement. Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. Staff records reviewed demonstrated that staff receive orientation and education on the incident and accident reporting process.</p> <p>Incident reporting forms are available in the staff room. Incident reports selected for review evidenced that the resident's family had been notified where appropriate, an assessment had been conducted and observations completed. Corrective actions arising from incidents were implemented. There is evidence of a corresponding note in the resident progress notes.</p> <p>Accident/incidents are graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared at monthly staff meetings</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p> | FA | <p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; identification verification; a position specific job description; and a signed employment agreement.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that</p> |

| | | |
|---|-----------|--|
| <p>employment practice and meet the requirements of legislation.</p> | | <p>require them including: RNs, pharmacists, general practitioners (GP), the nurse practitioner (NP); and podiatrist.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks, including personal cares.</p> <p>The organisation has a documented role specific mandatory annual education and training module/schedule. There are systems and processes in place that ensure all staff complete their required mandatory training modules and competencies.</p> <p>The CM and four of eight RNs have completed interRAI assessments training and competencies. Care staff complete annual competencies, for example: medication; moving and handling; and hoist use. Education session attendance records evidenced that ongoing education is provided relevant to the services delivered. Interviews and training records reviewed confirmed that all staff, including RNs undertake a minimum of eight hours relevant education and training hours per annum. An appraisal schedule is in place and all staff files reviewed for staff employed greater than one year, evidenced a current performance appraisal.</p> <p>The facility's staffing rationale informs recruitment processes to ensure that sufficient suitable staff are appointed and available to meet the needs of all residents including those with non-acute medical conditions.</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> | <p>FA</p> | <p>The facility currently has 70 staff consisting of: a management team; RNs; health care assistants (HCA); activities coordinators; and household staff. Household staff include: kitchen and housekeeping staff who provide services seven days a week.</p> <p>The organisation's staffing and skill mix policy and formula provide guidance to ensure safe staffing levels within the facility meet the needs of residents' acuity and the minimum requirements of the district health board (DHB) contract. Rosters are formulated at least two weeks in advance and staffing levels are reviewed to accommodate anticipated workloads, identified numbers, and appropriate skill mix, or as required due to changes in the services provided and the number of residents.</p> <p>There are RNs and HCAs available to safely maintain the rosters for the provision of care. There is pool of one RN and three HCAs as well as agency staff available to supplement rosters when needed to accommodate increases in workloads and the acuity of residents such as additional hospital level residents. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy and demonstrated that there are at least two RNs on each morning and afternoon shift, supported by six to seven HCAs. There is one RN on each night shift supported by four experienced HCAs.</p> <p>The BCM or the CM are rostered on call after hours, seven days a week.</p> <p>Observation of service delivery confirmed that resident needs were being met in a timely manner. Residents and family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed that whilst</p> |

| | | |
|--|----|--|
| | | busy at times, they have time to complete their scheduled tasks and resident cares. |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | FA | <p>Medicines are dispensed from the contracted pharmacy of choice into the robotic system packs. A safe medicines system is in place and was observed during the lunchtime medication round. The medicines and the medication trolleys are securely stored when not in use. Medications are checked when the packs are delivered from the pharmacy by the RNs on night duty and checked again when administered by the RNs giving out the medications at breakfast, lunch, dinner and in the late evening, if required. The staff administering medications are competent to do so. Medicines management competencies are completed annually. The medication storage fridge is monitored daily to ensure the temperature is maintained appropriately.</p> <p>The medication records are electronically maintained. Signatures for topical administration can be verified with the specimen signature list. Allergies and sensitivity are recorded on the electronic system and bright coloured stickers are used to alert staff when using the hard copy resident records. Stickers are also available for duplicate names, and for specific drugs. There is evidence of pharmacy input and audits being performed six monthly. The GPs/NP review all resident medications three monthly or more often as required. The NP interviewed confirmed this occurs. Legislative requirements are met.</p> <p>The CM or RN records any medications returned to the pharmacy. The CM or RNs order the medications as required. There is a system in place for checking drugs with two RNs, or one RN and one enrolled nurse. The drugs are checked weekly and balances are correct and verifiable.</p> <p>Medication errors are reported to the clinical manager and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for analysis of any medication errors and compliance with this process was verified.</p> <p>There are no residents self-administering medicines. Interviews with RNs confirmed they understand the process for safe and appropriate implementation of self-administration of medicines should the need arise. The CM confirmed there are no standing orders.</p> <p>Any prophylactic antibiotics are used within the infection prevention and control policy definition and recorded as required.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual</p> | FA | <p>Policies and procedures are available to guide food safety and all kitchen services. The kitchen services are managed by experienced chefs and the food service operations manager. There are two other chefs and three kitchen hands to cover this service on a daily basis. The food service operations manager is overall responsible for ordering all the food, equipment and resources and is responsible for daily events and all catering requirements. Temperature monitoring is recorded and maintained and the records were reviewed.</p> |

| | | |
|--|-----------|---|
| <p>food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | | <p>The BCM interviewed stated they are consulted if there are any issues. Food is stored effectively and safely. All equipment and resources are available inclusive of personal protective items such as gloves, aprons and hats.</p> <p>The RNs are responsible for ascertaining the nutritional needs of each resident on admission to this service. A copy of the assessment and dietary requirements is provided to the chef. Any special diets or requests are noted on the whiteboard for staff to view when preparing the individual meals.</p> <p>There is a large dining room/restaurant in the facility. There is a dining room on level two for those residents requiring assistance and this is adequately staffed during the meal times. A trolley is used to transport the food to this dining room and the food is temperature monitored throughout the process. Kitchen staff serves the meals to individual residents personally and this was observed. Food and fluid charts are used when monitoring individual residents as required. If a resident does not achieve the set fluid goal a short-term care plan would be implemented.</p> <p>Menu planning and menu reviews occur for the summer and winter seasons with the organisation's dietitian reports available. The menu review is based on the dietitian New Zealand audit for nutrition and dietary variety. Ministry of Health guidelines for older adults and Australian standardised definitions for texture modified food and fluids are being used. The menu plans rotate four weekly. There is evidence of all staff attending relevant education on infection control, first aid and safe food handling certificates. Cleaning schedules and audit requirements are implemented. The verification date for the food control plan is dated 18 April 2018. The licence for liquor on the premises was verified and is displayed. Interviews with residents/family members indicate that there is overall satisfaction with the food service 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>The resident records reviewed evidence and record interventions that are consistent with their identified needs and desired goals. Observations indicate residents are receiving appropriate care. Short-term care plans are used as needed. The residents interviewed report they are involved in their own care as much as possible and feel they are treated as an individual. The family members at interview expressed how the service meets the needs of the residents. Interventions are monitored and reviewed by the RNs and changed if not appropriate. Staff are informed of any changes at handover and in the progress records. RN progress notes include sufficient detail to inform care.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. Appropriate reassessments are performed and were sighted in the individual resident records reviewed.</p> <p>The NP interviewed discussed the improvement in care, management and consistency of services since the appointment of the new manager. Entries are made in the medical progress notes when the GP or NP review. Sufficient detail is documented with each consultation.</p> <p>A proactive approach to service delivery was evident in meeting minutes from a recent meeting between</p> |

| | | |
|---|----|--|
| | | management and the newly contracted GPs, who have been in the service for two weeks. This meeting addressed issues on how to improve service delivery, better communication and access to records to meet the needs of the residents. |
| <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> | FA | <p>There is an activities programme developed and implemented by the two activities coordinators for the rest home and the hospital level residents. The programme is varied and is displayed in all areas of the facility. The residents receive a copy of the weekly activities planner. The programme is verified and signed off by an occupational therapist employed by the organisation at monthly intervals.</p> <p>Resident meetings are held approximately three monthly and meeting minutes are available and sighted. The activities coordinators are both completing level 4 training. Records required are being maintained. Information is being transferred onto the individual residents' records and the activities plans are updated when changes occur. Time is allocated to the activities staff for maintaining the records. Attendance records are maintained and if a resident does not wish to attend, this is also recorded. Other options are provided if required. Activities are provided six days a week. On a Sunday the staff put a film on and often this is a time for family outings in the community.</p> <p>Activities assessments for each resident are undertaken on admission or later if information is needing to be gained from the family/whānau. Activity plans are documented in the long-term PCCP and reviewed at the same time the PCCP is reviewed six-monthly. The activities staff are involved in the multidisciplinary review meetings. External activities are provided in the community, for example; going to cafes, market days, creative arts, home visits with family/whānau and shopping trips. Resident independence is encouraged.</p> <p>Residents and staff report the activities are enjoyed and family can participate whenever they wish.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>The RNs complete and review assessments. Medical and specialist consultations are clearly documented in the resident records reviewed. Documentation reflects that the PCCPs are evaluated at least six monthly or more often if required. Evaluations are resident focused and indicate the degree of achievement or response to supports/interventions which are in place and progress towards meeting the desired outcomes. If a resident is not responding to the interventions being delivered, or their health status changes, then this is discussed with the GP/NP.</p> <p>Resident's changing needs are clearly described in the care plans reviewed. Short-term care plans are available and sighted for wound care management, pain, infections, changes in mobility, changes in food/fluid intake requirements, weight loss and skin cares or any other issues that may arise. Short-term care plans are also used following a fall or other adverse event. These processes are documented in the medical and nursing assessments and the resident's individual progress records.</p> |

| | | |
|--|----|---|
| | | The multidisciplinary reviews are organised by the RNs and families are invited to attend or contribute to the review process. Family and residents from both levels of the facility confirm their input into the multidisciplinary review meetings. The GP/NP, activities co-ordinator, physiotherapist, chef are included in multidisciplinary reviews. |
| 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 in the entrance to the facility. There have been no alterations to the building since the last audit. |
| 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 | <p>Surveillance frequency and type is set out in Oceania policy and is overall determined by the services infection control policies and procedures that are reflective of this aged residential care service. The infection surveillance data is required for the monthly clinical indicators. The services infection control manual is accessible to guide staff.</p> <p>Infection control data is collected on relevant types of infection such as urinary tract infections, lower respiratory infections, flu, chest infections, skin and wound infections, oral infections and other infections. The monthly data collected is forwarded to support office and the clinical indicators are then returned in the form of a report. The infection control coordinator is the CM. A RN is currently completing orientation to the role of infection control coordinator.</p> <p>The infection control report is submitted to the quality meeting with the benchmarking evidence and any recommendations. Results are fed back to the quality meeting and to staff at the monthly staff meetings. Minutes of the staff meetings are available to all staff and the minutes evidence infection control as part of the agenda template. Surveillance graphs express the results for all staff to see.</p> <p>The staff interviewed report they are kept informed and understand their responsibilities for reporting any signs and symptoms of a resident having an infection to the RNs and/or to the CM.</p> |
| Standard 2.1.1: Restraint minimisation Services demonstrate that | FA | The CM oversees the restraint minimisation and safe practice for this service. The restraint coordinator interviewed demonstrated understanding of restraint and enabler use. Staff interviewed understand that enabler use is voluntary and the least restrictive option to meet the needs of a resident. There are five |

| | | |
|---|--|--|
| the use of restraint is actively minimised. | | residents currently using bedrails for restraint. No residents are using an enabler. Training is provided to all staff annually as per Oceania protocol. |
|---|--|--|

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|--|-------------------|---|---|--|
| <p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p> | PA Low | The BCM is aware of situations which require the facility to report and notify statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. These are reported to the appropriate authority via Oceania support office staff. There is a requirement, as part of the conditions for certification, that the change of managers be reported, however, this could not be verified. | The MoH was not notified of the appointment of the current BCM in October 2018. | <p>Ensure that statutory and/or regulatory obligations in relation to essential notification reporting occurs to the correct authority.</p> <p>30 days</p> |

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.