# Oceania Care Company Limited - Takanini Lodge

## 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](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:** Takanini Lodge

**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: 23 April 2019 End date: 24 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:** 86

# 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

Takanini Lodge (Oceania Healthcare Limited) can provide care for up to 91 residents requiring rest home, hospital or dementia level of care. There were 86 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 the Counties Manukau 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, and staff.

There were no areas requiring improvement at the last audit and no areas identified as requiring improvement at this surveillance audit.

## 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 explained to residents and family on admission and available within the facility.

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.

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

## 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. |

Oceania Healthcare Limited is the governing body responsible for the services provided at Takanini Lodge.

The facility has implemented 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: absconders, 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 documented.

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.

Oceania Healthcare Limited human resource policies and procedures are implemented. 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 sufficient 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. |

Registered nurses assess residents on admission. Initial assessments and care plans are developed and implemented to guide staff during the first three weeks after admission. The interRAI assessments are completed by the registered nurse allocated for each resident. The interRAI assessment and the pre-admission information is used to develop the long-term care plan. Short term care plans are developed to manage any new problems or issues that might arise. Goals and outcomes are identified and reviewed regularly. Residents and families reported being informed and involved in care planning and evaluation. Residents and family stated that care is provided to a high standard.

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day, 7 days a week in the facility and are supported by care and allied health staff podiatrist, physiotherapist, diversional therapist, activities coordinators and a designated general practitioner. On call arrangements for support from senior staff are in place. Continuity of care is provided and shift handovers occur between all shifts.

The activities calendar is managed by a diversional therapist, two activities coordinators and one activities assistant. The activities are varied with individual and group activities being provided. The monthly calendar identified activities are planned in line with the residents’ goals and interests. Activities are provided for the 24-hour period in the dementia service and all residents had an individual plan in place. A van is available for outings in the community.

Medicine management occurs according to policies and procedures which meet legislative requirements. An electronic system is in place. Medication are administered by registered nurses and senior health care assistants all of whom have been assessed as competent to do so.

The food service meets the nutritional and other specific needs of the residents. Staff have completed food safety qualifications. The kitchen meets food safety standards and is registered for the food control plan implemented. Residents and family confirmed satisfaction with meals and hydration for all residents’ are maintained by staff.

## 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. |

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

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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 promotes restraint minimisation and safe practice. There were two restraints and no enablers in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. When enablers are used, enabler use is voluntary. Staff interviewed confirmed understanding of the restraint and enabler process.

## 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 clinical manager is responsible for infection surveillance. Infection surveillance is undertaken, analysed and trended. Results are reported to national support office. Graphs are developed and comparative summaries are documented in relation to the previous months. Feedback is provided to staff at staff meetings and at handover. Staff interviewed demonstrated current knowledge and practice in relation to the implementation of infection prevention and control.

## 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 | 39 | 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](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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The BCM is responsible for managing complaints. An up-to-date complaints register is in place that includes: 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 register. The complaints reviewed indicated that all complaints are investigated promptly, corrective actions are developed and implemented, and any issues raised are resolved in a timely manner. Staff interview and meeting minutes evidence that corrective actions arising from complaints are discussed at quality improvement and staff meetings.  Staff and resident interviews confirmed that the complaint process was explained to residents and family on admission. Complaint forms were made available on admission and additional forms are made available close to communal dining room, alongside a box to place the complaint into if required. 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 they were satisfied with the way any issues raised had been dealt with and the outcomes. Residents interviews confirmed an understanding of their rights to advocacy 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 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is policy to ensure open disclosure of adverse events where a resident incurred 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 status or a change in needs. Family are also invited to attend the resident’s six-monthly multidisciplinary team meetings. Family and resident interviews confirmed they are informed of any changes in the residents’ health status and they are involved in the resident’s care planning meetings.  Monthly 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. Interview with the business and care manager (BCM) and meeting minutes confirmed that resident meetings are well attended by residents. The minutes from March 2019 evidenced that subjects discussed included: satisfaction surveys results; cleaning; meals; activities; resident concerns; and education for residents on subjects such as how norovirus is spread and strategies to prevent this.  Residents and family are provided with copies of upcoming planned activities and menus. A two monthly newsletter provides updates on: activities and events that have occurred; upcoming events; new initiatives such as the ‘I love music’ promotion for residents; changes in the facility such as repairs and painting; the status of the facility such as: staff changes, and occupancy; and celebrations. Family and resident interviews confirmed that the BCM and staff were readily available, approachable and addressed any issues/concerns that had they had raised, promptly and effectively.  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 were two residents for whom English was not their first language. Family and staff interviews confirmed that there were staff who were fluent in each resident’s native language and able to communicate effectively with the resident. Interpreter services are also available through the Counties Manukau District Health Board (CMDHB) if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Oceania Healthcare Limited (Oceania) has a documented vision, mission and values statement which is displayed at the entrance to the facility and reflects a person-centred approach to all residents. These are communicated to residents, family and staff through information provided to new residents and families on admission. Staff also receive this information as part of the annual training programme. Oceania has documented overarching strategic goals and objectives, and these are reflected in the facility’s business planning objectives included within an annual budget specific to Takanini Lodge.  The Oceania Group executive management team provide support to the facility. Communication between the facility and executive management occurs at least monthly with the clinical and quality manager (CQM) providing support during the audit.  The facility inputs data on an ongoing basis into the Oceania reporting system. The facility and the executive management team receive reports on ongoing progress against identified indicators.  The BCM has been in the role for almost one year and has previous experience as a BCM and six years’ experience as a clinical manager (CM). The BCM is a registered nurse (RN) with a current practising certificate. The BCM is supported by a CM. The CM has been working for Oceania for over four years and has been 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.  Takanini Lodge is certified to provide care for up to 91 residents. These include: 22 designated rest home; 21 dementia and 48 dual purpose beds. The facility is certified to provide rest home, hospital care and dementia level care with 86 beds occupied at the time of the audit. Occupancy included: 25 residents requiring rest home level care; 41 requiring hospital level care and 20 requiring dementia level care. These numbers included one resident under the respite contract, three residents assessed at hospital level of care under the long -term services -– chronic health conditions contract and one assessed at dementia level of care who were under the age of 65 years. The facility has contracts with the CMDHB for: age-related care; respite care; long-term services-chronic health conditions and long-term services for under 65-year olds.  There are no residents with an occupational right agreement. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The facility utilises Oceania’s documented quality and risk management framework that is available to guide staff during service delivery. Policies are current, 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 on a notice board in the staff room, at staff meetings and policy updates are also provided as part of the relevant in-service education. Staff interviews confirmed that they are made aware of new and updated policies.  Service delivery is monitored through the organisation’s reporting systems utilising a range of clinical and key performance indicators such as: absconders; complaints; falls; infections; weight loss; wounds; incidents and accidents; and medication errors. There is evidence that an 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. All residents, including younger residents under the ages of 65, have input into quality improvements. This includes resident meetings and input into personal equipment and activities. Satisfaction surveys for residents and family are completed as part of the internal audit programme. Corrective actions are developed and implemented for any issues or trends identified through the surveys. Resident and family interviews confirmed satisfaction with service provision.  The facility has monthly staff, RN, quality improvement, health and safety, infection control, and restraint meetings. Meetings have a framework which is reflected in the meeting minutes, with timeframes and designated roles identified to implement any changes in practice and outcomes. The meeting minutes and communication with staff evidenced that all aspects of quality improvement including the results of internal audits and indicators, risk management and clinical indicators are discussed. Staff interviews reported that they are kept informed of quality improvements.  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 are two elected health and safety representatives. Staff interviews 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 promptly, with hazards being addressed and risks minimised. A current hazard register is available that is reviewed and discussed at monthly health and safety meetings when a new hazard is identified and at least annually. |
| 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 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 included the appointment of the BCM, a suspected norovirus outbreak and police involvement with an absconding resident. These are reported to the appropriate authority via Oceania support office staff. There have been deaths referred to the coroner. 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.  Staff interviews confirmed the facility promotes a ‘no blame culture’ that encourages staff to recognise and report 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 they receive orientation and education on the incident and accident reporting process.  Accident/incident reporting forms are readily 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 accidents/incidents were implemented. There is evidence of a corresponding note in the resident progress notes.  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, health and safety and quality improvement meetings. |
| 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 | 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.  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 require them including: RNs, pharmacists, general practitioners (GP), dietitian; and podiatrist.  An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on several tasks, including personal cares.  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.  The BCM, CM and 12 of 13 RNs have completed interRAI assessments training and competencies and 1 RN is currently enrolled to undertake the interRAI training. Care staff complete annual competencies, for example: hand hygiene; medication administration; moving and handling; restraint; and hoist use. Education session attendance records evidenced that ongoing education is provided relevant to the services delivered including residents under the age of 65 years. 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.  Thirteen of fifteen HCAs working in the dementia unit have completed required dementia unit standard training, one is undergoing training and one is enrolled.  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. |
| 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 facility currently has 86 staff consisting of: a management team; RNs; HCAs; a diversional therapist; activities coordinators; and household staff. Household staff include: a laundry assistant; kitchen and housekeeping staff who provide services seven days a week.  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 DHB contract. Rosters are formulated and drafted four weeks in advance and finalised at least two weeks in advance. 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.  The facility is divided into three distinct areas. There are two parallel wings identified as hospital one and hospital two. These two wings include a mix of both rest home and hospital beds in each wing. Interview confirmed that placement of residents in these wings is related to level of care needs and independence of residents, for example, residents with higher needs were closer to the nurses’ station. In addition, there is a third wing designated as the dementia unit, that is in close proximity to the two hospital wings. There is a nurses’ station in each of the three wings. Observation on the days of the audit identified that staff could move quickly and without hinderance across all three wings if required.  There are sufficient RNs and HCAs, available to safely maintain rosters for the provision of care. In addition, there is a pool of casual staff including three RNs, and five HCAs as well as agency staff who are available to supplement rosters when needed to cover staff absences and accommodate increases in workloads. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy. The two hospital/rest home wings are covered by at least one RNs in each wing on the morning and afternoon shifts. There is one RN for the entire facility on the night shift. On each wing there are between five and six HCAs on the morning shift, two to three on the afternoon shift and two on night shift. In the dementia wing there is a RN on each morning shift Monday through to Friday supported by at least two HCAs on all shifts, seven days per week. There are at least two staff members with a current first aid certificate on each shift.  The BCM or the CM are rostered on call after hours, seven days a week.  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 they have time to complete their scheduled tasks and resident cares. |
| 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 medicine management system is documented, implemented and complies with legislation, protocols and guidelines.  The service uses pharmacy pre-packaged medicine that is checked by the RNs on delivery from the pharmacy. An electronic medication system is used. Weekly medicines checks and six monthly stocktakes are conducted and confirmed that the quantity of actual medications in stock reflected the expected stock levels. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are stored appropriately. Review of the medication fridge confirmed that the service does not store or hold vaccines and interviews with the RN and the CM confirmed they do not hold any vaccines on the premises. The medication fridge temperature is monitored and was within the recommended range.  A safe system for medicine management was observed on the days of the audit. The staff observed demonstrated knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Education is provided at the compulsory organisational study days and in-service training is provided at staff meetings. Education for residents is provided at the resident meetings and one-on-one as needed.  Prescribing practices in line with legislation, protocols and guidelines were evidenced on the electronic system inclusive of allergies and sensitivities and the dates of the last medication review by the GP. The requirements for pro re nata (PRN) medicines were effectively met. Outcomes were documented in progress records.  Medication errors are reported to an RN and/or CM and recorded on an incident form. There is a process for analysis of medication errors and compliance with this process is verified. There are no standing orders.  Residents, including young people with disabilities, have the opportunity to self-administer medicines. There was one resident self-administering medication during the audit. A process is in place to ensure ongoing competency of the resident and this is authorised by the GP. |
| 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 | All food services are provided on site by qualified chefs and kitchen staff. The food service is in line with recognised nutritional guidelines for older people. Meals are served in the main dining room, in close proximity to the kitchen for hospital and rest home level residents. The meals for the dementia service are delivered in a bain-marie and served to the residents by staff.  Residents’ dietary profiles are developed on admission and identify the residents’ dietary requirements and preferences. The dietary profiles are communicated to kitchen staff on admission to the facility and when a resident’s dietary needs changes. Diets are modified as required and the chef interviewed confirmed awareness of the dietary needs of all residents. Supplements are provided to residents with identified weight loss problems. There is sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.  All kitchen personnel have completed relevant training on food safety management and infection prevention and control. The chef interviewed is responsible for ordering all food to meet the requirements of the menu plans which are reviewed two yearly. Food is stored appropriately in fridges, freezers and coolers and monitored three times a day. Dry stock is stored in the pantry. Emergency food supplies for three days are available should this be needed. All food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit meets the requirements of the standard and the food control plan.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. |
| 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 are completed by an RN and based on assessed needs, desired outcomes and goals of the residents. Care planning includes specific interventions for both long-term and acute problems. Short-term care plans are documented when any issues arise and are reviewed daily or as required.  The GP documentation and records reviewed were current. Interviews with residents and families confirmed that the care and treatment meet the residents identified needs. Staff interviews confirmed they are familiar with the needs of the residents including residents in the dementia unit. A range of equipment and resources was available and suited to the level of care provided, and in accordance with the residents’ needs. Family communication records are maintained and this is evidenced in resident records.. The nursing progress records and observation records are maintained. Appropriate links are developed and maintained with other services where required for non-acute medical residents. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities calendar is developed and implemented by a diversional therapist, two activities coordinators and one activities assistant. The staff cover and provide activities for the residents across all services. The activities calendar was reviewed, displayed and implemented. The calendar includes a wide range of activities which incorporate, education, leisure, cultural, themes and community events. The three residents under 65 years of age in the hospital are provided with their own programme incorporating personal goals and interests to pursue as well as being able to join in the other organised activities if they choose to do so. Activities are provided for the dementia service residents, including the younger resident, which cover the 24 hour period. Outings in the community are encouraged and three staff are designated drivers for the facility’s van.  The residents’ activities assessments are completed within three weeks of the residents’ admission to the facility. Information on residents’ interests are gathered during an interview with the resident and their family/whānau. An activities care plan is developed for each individual resident, including the residents under 65, that reflects the resident’s preferred activities. The individual activities plans are reviewed six-monthly at the same time the care plans are reviewed.  There was evidence the activities staff are involved in the multidisciplinary reviews and the interRAI evaluation process. The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging in a variety of activities both in the dementia service and the rest home and hospital services. |
| 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 progress records. If any changes occur, it is reported to the RN or the CM. Formal care plan evaluations occur six monthly in conjunction with the six monthly interRAI re-assessments and/or when any needs change for a resident. All evaluations are completed by the RNs. Short-term care plans were in place and reviewed for short-term problems, for example, wounds, skin tears and urinary infections. Progress was evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| 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 | Surveillance is appropriate to that recommended for long-term residential care facilities with infection definitions reflecting a focus on symptoms rather than laboratory results. These include, for example, urinary tract infections, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin conditions.  The infection prevention and control coordinator is the CM. When an infection is identified, it is documented on a clinical record sheet. The infection prevention and control coordinator collates information related to infections and sends this to the organisation’s national support office on a monthly basis. The quality team analyses the recorded infections to identify any trends, possible causative factors and required actions. In addition, graphs are produced that identify any trends and comparative studies are documented from the previous month. Data is benchmarked externally with other aged care providers within the organisation. Benchmarking provides assurance that infection rates in the facility are below average for the sector.  Results of the surveillance programme are then shared with staff via the staff monthly meetings and at staff handovers. This was confirmed in meeting minutes sighted and interviews with staff. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The Takanini Lodge restraint minimisation policies and procedures comply with legislative requirements. The restraint coordinator is a RN who was not available on the day of the audit. A signed position description was sighted. The CM was interviewed and stated that no enablers were currently being used and two residents were using restraints (chair briefs) at the time of the audit. The restraint register reviewed was maintained and current. Required documentation relating to restraint use is recorded. Staff receive restraint minimisation and safe practice education annually as part of the mandatory education programme and RN study days. |

# 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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| 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, 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.