

Oceania Care Company Limited - Eversley 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: Eversley Rest Home and Village

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 28 September 2017 End date: 29 September 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: 50

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

Eversley Rest Home and Village can provide care for up to 50 residents. There were 50 residents at the 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 district health board. The audit process included the review of policies, procedures, and residents and staff files, observations and interviews with residents, family, management, and staff.

The business and care manager is responsible for the overall management of the facility, including clinical care, and is supported by a clinical manager and the regional and executive management teams. Service delivery is monitored.

Corrective actions required from the last audit relating to informed consent, interRAI and medication have been addressed. There is one new corrective action that relates to infection prevention and control.

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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Family are updated in a timely manner if any changes occur in a resident's condition. Resident and family meetings are held monthly for both the dementia unit and the rest home. Interpreter services are accessed when required and a multicultural staff mix enables interpretation by staff where appropriate.

Open communication between staff, residents and families is promoted and confirmed.

A complaints register is maintained and up to date. Complaints are investigated within the required timeframes and documentation is maintained.

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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Oceania Healthcare Limited is the governing body and is responsible for the service provided at Eversley Rest Home and Village. The business and care manager is a registered nurse who holds a current practising certificate and is qualified and experienced in management systems and processes. The clinical manager supports the business and care manager in clinical care delivery. The business and care manager and the clinical manager are supported by the clinical and quality manager (regional), the operations manager (regional) and the senior clinical and quality manager (national) regarding oversight of the service.

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

There are human resource policies implemented including recruitment, selection and orientation. Staff receive education at orientation and as part of the ongoing training programme. Rosters are adjusted according to the number of residents in the facility and acuity levels. Staff are allocated to support residents as per their individual needs. Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed.

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.
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Residents are assessed by registered nurses on admission and their needs assessments are completed within the required timeframes.

Person-centred care plans are individualised and based on an interRAI assessment and a comprehensive and integrated range of clinical assessments. Short-term care plans are in place to manage short-term problems. Residents' records reviewed demonstrate their needs, goals and outcomes are identified and reviewed at regular intervals. Residents and their families confirmed they are informed and involved in care planning and evaluation of care. Handovers guide continuity of care.

The diversional therapist manages the activities programme which is reviewed annually. The programme provides residents with a variety of individual and group activities. The service uses their facility bus for outings in the community.

Medicines management occurs according to policies and procedures which are in alignment with legislative requirements and implemented using an electronic system. Medicines management

The kitchen meets food safety standards. Residents confirmed satisfaction with meals.

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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There is a current building warrant of fitness. There have been no building modifications 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.
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The organisation implements policies and procedures that support the minimisation of restraint. Enabler use is voluntary. There were no enablers or restraints at the time of audit. Restraint is only used as a last resort when all other options have been explored. Staff interviews confirmed understanding of the restraint and enabler processes.

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.		Some standards applicable to this service partially attained and of low risk.
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Infection control management systems are in place to minimise the risk of infection to residents, visitors and staff. Infection data is collated monthly, analysed and reported to Oceania Healthcare Limited support office, management and staff. Results of the surveillance are acted upon, evaluated and reported.

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	17	0	1	0	0	0
Criteria	0	40	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
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	<p>There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent. Resident files identified that informed consent is obtained. Staff confirmed their understanding of informed consent processes.</p> <p>Service information pack includes information regarding informed consent. The business and care manager (BCM) and clinical manager (CM) discuss informed consent processes with residents and their families during the admission process. The policy and procedure includes guidelines for consent for resuscitation/advance directives and resuscitation orders. Review of resident files demonstrated consents including advance directives and enduring power of attorney are completed for residents where applicable.</p> <p>The previous corrective action regarding written consent is closed out.</p>
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected,	FA	<p>The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance of the facility.</p> <p>A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; the outcome and the agreed action. The complaints register includes documentation of verbal complaints. Evidence relating to each complaint lodged is held in the complaints folder. Complaints reviewed in 2017 indicated that complaints are investigated promptly with issues resolved in</p>

and upheld.		<p>a timely manner.</p> <p>The BCM is responsible for managing complaints. Residents and family confirmed that they are aware of the complaints process if they need to make a complaint.</p> <p>Residents and their families can raise any issues they have during resident meetings, as confirmed during interviews. Projects and changes have been completed as a result of identifying shortfalls through review of complaints, adverse events monitoring and suggestions from residents.</p> <p>There have been no complaints with the Health and Disability Commission since the previous audit or with other external authorities.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Information is provided to residents and their families as part of the information admission pack. The resident admission agreement is signed by residents or their representative upon entry to the service. The agreement includes information about the services that are included in service provision, including details of services that will incur cost outside the subsidy agreement.</p> <p>Family members confirmed they are kept informed of any change in the resident's condition and any incidents/accidents that occur. Communication with family members is consistently recorded in the residents' progress notes and on family communication forms. Monthly newsletters are sent to families. Open disclosure policy and procedures are in place to ensure staff maintain open and transparent communication with residents and families. There was evidence of resident/family input into the care planning process.</p> <p>Staff confirmed their understanding of the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Health and Disability Commission Code of Health and Disability Services Consumers' Rights (the Code). Monthly residents' meetings for both the dementia unit and the rest home provide a forum for discussion.</p> <p>Interpreter services are available through the district health board (DHB), if required. Staff knew how to access this service if needed but reported this was rarely needed as the facility has a multicultural staff mix, which enables staff to act as interpreters.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and</p>	FA	<p>Eversley Rest Home and Village is part of Oceania Healthcare Limited (Oceania) with the executive management team including the chief executive, general manager, regional manager, operations manager and clinical and quality manager (CQM) providing support to the service.</p> <p>There are values, goals and a philosophy documented in the strategic overview of the service. The strategic plan also includes a marketing plan and a strengths, weaknesses, opportunities and threats analysis. These are communicated to residents, staff and family through information in booklets, in the staff orientation and the</p>

appropriate to the needs of consumers.		<p>website.</p> <p>Communication between the service and managers takes place at least monthly. The CQM and the regional manager provided support during the audit.</p> <p>The facility can provide care for up to 50 residents. During the audit there were 50 residents living at the facility, including 33 residents requiring rest home level of care and 17 residents requiring dementia level of care. These numbers include three residents in rest home care under a mental health contract.</p> <p>The BCM is responsible for the overall management of the facility and had been in the role for 4 years, with 18 years' experience in aged care.</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>	FA	<p>The facility has a documented quality risk management framework incorporated in the business plan to guide practice.</p> <p>The service has implemented organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Policies are linked to the Health and Disability Service Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies were noted to be readily available to staff in the staff room. New and revised policies are signed by staff to confirm they have read and understood them.</p> <p>There are monthly meetings that include the following: staff; quality improvement; health and safety; residents and infection control. Quality activities and weekly management meetings also occur. Minutes of all these meetings are documented. Staff confirmed they are kept informed of quality improvements.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service. This includes a documented hazard management programme and a hazard register for each part of the service. There is evidence that any hazards identified are signed off as addressed and the risks are minimised or isolated.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, residents and family surveys and implementation of an internal audit programme. Quality improvement data is analysed for opportunities to improve service delivery.</p> <p>Corrective action plans are documented. The BCM and CM could describe how issues have been addressed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	FA	<p>The BCM and CM are aware of situations in which the service would need to report and notify statutory authorities including situations such as: police attending the facility; pressure injuries; unexpected deaths; critical incidents; infectious disease outbreaks and change of management.</p>

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>Staff receive education on the incident and accident reporting process at orientation and as part of the ongoing training programme. Staff understand elements of the adverse event reporting process and could describe the importance of recording near misses.</p> <p>Incident/accident reports reviewed had a corresponding note in the progress notes to inform staff of the incident/accident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place. Incident/accident reports are signed off by the BCM.</p>
<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>Human resource policies and processes are in place and implemented. All registered nurses (RN) hold current annual practising certificates and visiting practitioners' practising certificates reviewed were current. Visiting practitioners include: general practitioners (GP); pharmacists; dietitian and podiatrist. Staff files include employment documentation such as: job descriptions; contracts; and appointment documentation on file. Police and drug checks are completed and an annual appraisal process is in place with all applicable staff having a current performance appraisal.</p> <p>All staff have completed a comprehensive orientation programme. Staff confirmed the buddy system that is in place for new staff and that the competency sign off process is completed.</p> <p>Mandatory training is identified on a training schedule. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training including external training programmes are maintained. The service has a varied approach to ensuring that staff receive annual training that includes attendance at training sessions and annual individualised training around core topics. The training register and training attendance sheets demonstrate staff completion of annual medication and competencies. All the four RNs (including the BCM) have completed interRAI training. Staff have completed training around pressure injuries in 2017. Staff working in the dementia unit completed appropriate training as required by the contractual agreement with the district health board (DHB).</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>The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Flexible shifts are utilised to facilitate escalations in acuity levels. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.</p> <p>There are 44 staff, including clinical staff, staff who facilitate the activities programme and household staff. There is always a RN on seven days a week. The BCM is on call. If the BCM is on leave, the CM takes over the on-call role.</p> <p>Evidence reviewed demonstrated that residents requiring rest home and dementia level of care were encouraged to be as independent as possible. Residents and families confirm staffing is adequate to meet the</p>

		residents' needs.
<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>The medicine management system is documented and implemented and complies with legislation, protocols and guidelines. The service uses pre-packaged medicine that is checked by the RN on delivery. An electronic medication system is used. Weekly checks and six-monthly drug stocktakes are conducted. Drugs registers were up to date. The medication refrigerator temperatures are monitored. The service has a system in place for returning expired or unwanted medications to the pharmacy. All medications are stored appropriately.</p> <p>The staff administering medication complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled. There were no residents who self-administered medications on audit days.</p> <p>The previous corrective actions relating to medicines management are closed out.</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>	FA	<p>Meals are prepared on site. The seasonal menu has been reviewed by a dietitian. Kitchen staff have current food management handling/food safety certificates. Diets are reviewed and modified. The chef confirmed awareness of the dietary needs of residents.</p> <p>Residents' dietary profiles are developed on admission which identify the residents' daily dietary requirements and preferences. The dietary profiles are communicated to kitchen staff on the resident's admission to the facility. When a resident's dietary needs change, the kitchen is informed. Nutritional assessments are reviewed six-monthly. Supplements are provided to residents with identified weight loss problems.</p> <p>Food containers are labelled and dated and decanted food had records of expiry dates recorded. Records of temperature monitoring of food, fridge refrigerators and freezers are maintained. Regular cleaning is undertaken. Food services comply with current legislation and guidelines. Interviews with residents and their families confirmed satisfaction with the food service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The residents' needs, outcomes and goals are identified via the assessment process and recorded. The facility has processes in place to seek information from a range of sources, for example: family; GP; specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.</p> <p>The residents' files evidence the presence of residents' discharge/transfer information from the district health board (DHB), where required. The facility has appropriate resources and equipment, as confirmed at staff interviews. The assessments are conducted in a safe and appropriate setting including visits from a nurse</p>

		<p>practitioner (NP) and the GP. In interviews, residents and family confirmed their involvement in the assessments, care planning, review, treatment and evaluations of care.</p> <p>The previous corrective action regarding interRAI assessments not being completed is closed out.</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>	FA	<p>Residents' care plans are based on assessed needs, desired outcomes and goals of the residents. Care plans are completed by RNs and include specific interventions for both long-term and short-term problems.</p> <p>The GP documentation and records are current. Interviews with residents and families confirmed care and treatments meet their needs. Staff interviews confirmed they are familiar with the needs of the residents. Family communication is recorded in the residents' files. The progress notes and observation charts are maintained.</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>	FA	<p>The activities programme is developed and implemented by a diversional therapist (DT). The residents' activities assessments are conducted by the DT within three weeks of the residents' admission to the facility.</p> <p>Residents' interests are recorded during an interview with the resident and their family. The activity care plan is part of the long-term care plan and reflects the residents' preferred activities. Residents in the dementia unit have 24 hour behaviour management charts to guide staff in their care.</p> <p>The residents and their families reported satisfaction with the activities provided. During the on-site audit the residents were observed engaging in a variety of activities and outings. Resident meetings are conducted monthly for both the rest home and the dementia unit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term and the short-term care plans are evaluated in a timely manner. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Residents' responses to the treatment are documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved.</p> <p>The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved. Short-term care plans are developed when needed. Short-term goals and required interventions are identified for short-term problems.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>A current building warrant of fitness is displayed. There have been no building modifications since the last audit.</p>

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
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.	PA Low	<p>The infection control surveillance policy identifies the requirements around the surveillance of infections. The infection logs are maintained and collated monthly by the infection control nurse (ICN). A RN is the ICN.</p> <p>Surveillance forms allow for the documentation of a wide variety of data including the types of infections, laboratory data, outcomes, and dates of when the infections were resolved, however, this is not consistently documented.</p> <p>Collated infection control data is communicated as clinical indicators to the Oceania support office, management and staff. The GP interview confirmed infections are reported in a timely manner. Interviews with staff evidenced they are made aware of infections through feedback from the RNs, verbal handovers, short-term care plans and progress notes.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>The Oceania restraint minimisation and safe practice handbook and policies comply with legislative requirements. The restraint coordinator is the BCM. A signed position description was sighted.</p> <p>There were no residents using enablers or restraints during the on-site audit days. The restraint register is available, should they need to use enablers. Staff receive training in relation to restraint and enabler management as well as challenging behaviour management and de-escalation techniques through the Oceania study days and RN study days.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	PA Low	The service completes surveillance of all infections. Surveillance, conclusions and recommendations to assist in achieving infection reduction are documented. The documentation of surveillance does not currently include all the information to allow the organisation to consistently follow up on the outcomes of infections.	Types of infections, laboratory data, outcomes and dates of when the infections were resolved, are not consistently documented.	Documentation of infection prevention and control surveillance to include all information to support monitoring and reduction of infections. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.