Oceania Care Company Limited - Franklin Rest Home

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:	Franklin Rest Home
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: 15 October 2018 End date: 16 October 2018

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: 43

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

Franklin Rest Home provides rest home, hospital and dementia level of care for up to 44 residents. There were 43 residents residing at the facility on audit days.

This surveillance audit was conducted against a sub set of the Health and Disability Service Standards and the service contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, and observations and interviews with residents, family, management, staff and a general practitioner.

The previous certification audit did not identify any areas requiring improvement. This surveillance audit identified three areas requiring improvement relating to corrective action plans, adverse events and staff education.

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 accessible and available to residents and their family.

Residents are informed and have choices related to the care they receive. There is a documented and implemented complaints management process that complies with the Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. A complaints register is maintained and complaints/concerns are viewed as an opportunity for improvement.

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 medium or high risk and/or unattained and of low risk.

Franklin Rest Home is part of the Oceania Healthcare Limited. Oceania Healthcare Limited has a documented quality and risk management system that supports the provision of clinical care and services at the facility. The quality and risk performance is monitored by the business and care manager and communicated monthly to Oceania Healthcare Limited support office. Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators. These are used to provide comparisons with other Oceania Healthcare Limited residential care facilities and inform staff.

The facility is managed by a business and care manager and a clinical leader who is responsible for the oversight of the clinical services in the facility.

Policies and procedures are reviewed at Oceania Healthcare Limited support office and these are current.

There are human resource policies relating to: recruitment; selection; orientation; staff training and development.

The 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. Staff are allocated to support residents' individual needs.

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 care plans guide service delivery during the first three weeks after admission.

The interRAI assessment process is used to identify residents' needs and completed within the required timeframes.

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

The activity programme is managed by the activities coordinators and reviewed by a diversional therapist. The programme provides residents with a variety of individual and group activities. The service uses its facility bus for outings in the community.

Medicine management occurs according to policies and procedure, in alignment with legislative requirements and consistently implemented using an electronic system. Medications are administered by registered nurses and senior healthcare assistants. Medicines management competencies for staff who administer medicines were current.

The facilities food service meets the nutritional and other specific needs of the residents. Staff have food safety qualifications. The kitchen was clean and 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.

The facility has a current building warrant of fitness. There has 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 organisation implements policies and procedures that support the minimisation of restraint.

There were no enablers in use and three residents using four restraints 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 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.		Standards applicable to this service fully attained.

Infection surveillance is undertaken, analysed, trended and benchmarked. Results are reported to the Oceania Healthcare Limited support office. Surveillance records showed evidence of follow-up of infections, when required.

The infection prevention and control programme is reviewed annually. Staff 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	13	0	2	1	0	0
Criteria	0	36	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisation's complaints policy and procedure are in line with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code) and includes periods for responding to a complaint. The complaint forms are available at the entrance to the facility. A complaints register is in place and includes: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint's folder. The two complaints reviewed for 2018 indicated that the complaints were investigated promptly with the issues resolved in a timely manner. The residents and their family are informed about the complaints process on admission to the facility. Residents and family members interviewed stated that they would feel comfortable complaining. The business and care manager (BCM) stated that there had been no complaints with the Health and Disability Commission or with other authorities since the previous audit.
Standard 1.1.9: Communication Service providers	FA	Policies and procedures relating to accidents/incidents; complaints and open disclosure, guide staff on the process of open disclosure of information. Management and staff notify family/enduring power of attorney of accidents/incidents that occur or when a resident's condition alters. Family contact is recorded in the residents' clinical files. Interviews with family members confirmed they are kept informed. Family members

communicate effectively with consumers and provide an environment conducive to effective communication.		also confirmed that they receive newsletters from the facility and are invited to attend resident meetings. Interpreter services are available from the district health board (DHB). There were no residents requiring interpreting services on audit days. The facility information pack is provided to residents and family and contains all required information regarding the services provided at the facility. Specific information is provided to families of residents with dementia. Residents or family sign an admission agreement on entry to the service.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Franklin Rest Home is part of the Oceania Healthcare Limited (Oceania). The BCM is responsible for the overall management of the facility. They have been in this role for approximately two months. Prior to this appointment the BCM had been working in aged care as an administrator since 2004, including as the Oceania regional administrator since 2016. The BCM is supported in their role by the Oceania support office staff. The Oceania general manager provided support during this on site audit. The BCM stated they had received orientation to their position from the regional clinical and quality manager and the operations manager. The clinical leader (CL) is responsible for oversight of clinical services. The CL is a registered nurse (RN) who has been in this position for five years. Oceania has a clear mission, values and goals and these are communicated to residents, staff and family. The facility can provide care for up to 44 residents. There are 26 dual purpose rooms for either rest home or hospital level of care and 18 beds in the dementia unit. There were 7 rest home residents, 18 hospital residents and 18 residents with dementia residing at the facility. There was one resident under an interim care scheme contract at hospital level of care, funded by the DHB orthopaedic department. This contract was for a six week duration and the resident had been at the facility for two of the six weeks.
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	PA Low	Franklin Rest Home uses the Oceania quality and risk management framework that is documented to guide practice. The BCM reports to the Oceania support office monthly. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. The policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. The policies are available to staff in hard copy. New and revised policies are communicated to staff to ensure staff are kept informed.

improvement principles.		The service delivery is monitored through: complaints; review of incidents and accidents; surveillance of infections; pressure injuries; soft tissue/wounds; and implementation of an internal audit programme. Corrective action plans are not consistently completed for internal audits and adverse events when this is required. The quality data evidences: collection; collation; identification of trends and analysis. Benchmarking reports are produced by the Oceania support office and provide comparisons with other Oceania residential care facilities. This data is shared with all Oceania facilities, staff and management. Facility's meetings and meeting minutes provide evidence of communication with management and staff around all aspects of quality improvement and risk management. Interviews with staff confirmed they are informed about quality activities. There are planned resident and family meetings that keep residents informed of any changes and provide opportunity for discussions. There is a six monthly family and resident satisfaction survey. The survey was last conducted in August 2018 and results indicated overall satisfaction with services provided. Oceania is a member of Site Safe New Zealand Limited. The Oceania health and safety annual plan records actions required to be carried out and there is evidence this is being implemented. The progress of this plan is reviewed by the BCM and at the health and safety monthly meetings. Health and safety objectives are recorded. Risk/hazard registers are current, documented and reviewed. Registers include risk relating to clinical, human resource management and environmental risks.
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.	PA Moderate	The BCM and CL are aware of the situations/events when they would need to report and notify statutory authorities of the events occurring. There was one event notified to the Oceania support office and HealthCERT relating to a stage 3 pressure injury. The BCM stated in interviews there have been no investigations by the coroner since the previous audit and no requirement for notification of uncontrollable events. Oceania are aware of informing HealthCERT and the DHB when clinical managers change. On interview, it was noted that it is not usual practice for Oceania to inform HealthCERT when a facility manager changes. The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff receive education at orientation and as part of the ongoing mandatory training programme on the incident/accident reporting process. Incident/accident reports documented had a corresponding note in the progress notes to inform staff of the incident/accident. The staff interviews confirmed their understanding of the adverse event reporting process, however, the accident/ incident reports reviewed did not consistently have a corrective action plan (refer to 1.2.3.8). Neurological recordings were not consistently completed for unwitnessed falls. There was evidence of open disclosure for each recorded event.

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.	PA Low	The RNs and the CL have current annual practising certificates, along with other health practitioners involved with the service. The staff files reviewed included all required employment documentation including but not limited to: appointment documentation; signed contracts; job descriptions; reference checks and interviews. There is a staff appraisal process in place and this is up to date. There are documented orientation programmes for specific staff roles within the organisation and include the essential components of the service provided. All staff complete an orientation programme and this was evidenced in staff files reviewed. The health care assistants (HCA) are paired with a senior HCA for shifts or until they demonstrate competency on a number of tasks including personal cares. A new staff member interviewed stated that the orientation programme is followed. The organisation has a mandatory education and training programme that is required for staff under the Age-Related Residential Care (ARRC) Services Agreement and the Health and Disability Sector Standards, however, not all staff in the dementia unit have not completed the required education relating to dementia. The staff attendances are documented with all staff undergoing this mandatory training. The education and training hours were at least eight hours a year for each staff member. InterRAI training and competency has been achieved by total of three RNs (including the CL). Clinical competencies are completed by care staff and include: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; restraint; nebuliser; blood sugar and insulin; and assisting residents to activities of daily living.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing and skill mix policy is documented and implemented. The interview with the BCM confirmed the 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 (refer to 1.2.7.5). The rosters sighted evidenced there is a RN on duty 24 hours a day seven days a week. Management confirmed additional staff are rostered if resident numbers or acuity increases. The BCM and the CL work Monday to Friday. The BCM is on call for non-clinical matters and the CL is on call for any clinical matters. The HCA cover aligns with ARRC contract requirements. Staff interviews confirmed they are able to get through their workload. Family and residents' interviews confirmed satisfaction with services provided.
Standard 1.3.12: Medicine	FA	The medicine management system is documented and implemented and complies with legislation, protocols

Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		and guidelines. The service uses pharmacy pre-packaged medicine that is checked by the RN on delivery. An electronic medication system is used. Weekly checks and six-monthly stocktakes are conducted and confirmed that stock levels were correct. The medication refrigerator temperatures are monitored. 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. Interviews with the BCM and the CL confirmed they do not hold any vaccines on the premises and have not completed training on the national standards that authorise vaccination processes. 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 self-administering medications during the onsite audit days.
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 meals are prepared on site and served in different dining rooms. The seasonal menu has been reviewed by a dietitian. The food control plan's expiry date for implementation is January 2019. Kitchen staff have current food management certificates. Diets are modified as required and the cook confirmed awareness of the dietary needs of residents. Residents' dietary profiles are developed on admission and identify the residents' dietary requirements and preferences. The dietary profiles are communicated to kitchen staff on a resident's admission to the facility, when a resident's dietary needs change and when dietary profiles are reviewed six monthly. Supplements are provided to residents with identified weight loss problems.
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 the 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. The GP documentation and records are current. Interviews with residents and families confirmed that care and treatment meets residents' needs. Staff interviews confirmed they are familiar with the needs of the residents. Family communication is recorded in the communication records in the residents' files. The nursing progress notes and observation charts are maintained.
Standard 1.3.7: Planned	FA	The residents' activities programme is developed by the activities coordinator and reviewed by a diversional therapist. The activities programme was implemented. The residents' activities assessments are completed

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.		within the three weeks of the residents' admission to the facility. Information on residents' interests are gathered during an interview with the resident and their family. The activity care plan is part of the PCCP and reflects the residents' preferred activities. Residents in dementia care have additional activities to help manage behaviour over 24 hours. The residents in the dementia unit have challenging behaviour management plans on file. There was evidence the activities staff are part of 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 and outings. Resident meetings are conducted monthly.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Person centred care plans 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 their treatment are documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. Short-term care plans are developed for acute problems when needed and record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building warrant of fitness is current. There have been no structural alterations to the facility 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	The infection control programme is site specific and reviewed annually. The surveillance policy identifies the requirements around the surveillance of infections. The infection logs are maintained and collated monthly by the CL. The CL is the infection prevention and control nurse. Collated data are communicated as clinical indicators to the Oceania support office and to management and staff. Residents' files evidenced that those residents diagnosed with an infection had short-term care plans in place. The GP interview confirmed infections are reported in a timely manner. In interviews, staff reported they are made aware of any infections through feedback from the RNs, verbal

		handovers, short-term care plans and progress notes. This was confirmed during attendance at the handover and review of the residents' files. The CL confirmed that there had been no outbreaks of infection at the facility since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The Oceania restraint minimisation and safe practice handbook and policies comply with legislative requirements. The restraint coordinator is the CL. A signed position description was sighted. There were no residents using enabler at the time of the on-site audit. Interviews with staff confirmed that enabler use, when applicable, is voluntary. The service had three residents using four restraints. Restraints included three bedrails and one lap-belt. The restraint register is maintained and current. Required documentation relating to restraint is recorded. Staff receive restraint education via the Oceania study days 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	The Oceania internal audit schedule is documented and the internal audits are conducted according to the schedule. The internal audit schedule and the internal audits for 2018 were reviewed. The areas identified as requiring improvement following internal audits were not always documented on a corrective action plan. The corrective action plans did not always evidence sign off from the appropriate staff member. Three of the 14 internal audits evidenced this. The adverse events are recorded on the accident/incident forms. Review of 15 adverse events evidenced the corrective actions required were not completed in 11 of the forms.	Corrective action plans arising from internal audits and adverse events are not consistently documented, implemented and signed off.	Provide evidence corrective action plans are documented and implemented where required. 180 days
Criterion 1.2.4.3 The service provider	PA Moderate	There is a policy for staff to follow that details the requirements for observation for residents who have sustained unwitnessed	Neurological observations are not consistently	Provide evidence of neurological

documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.		falls. Review of 15 adverse events relating to unwitnessed falls evidenced 2 events required for the residents to be admitted to DHB following the falls. Of the remaining 13 adverse events, 1 event did not have neurological observations conducted and 12 events did not have neurological observations continued for the required period of observation. The time of neurological observations varied from 1.5 hours to 12 hours.	completed as required following unwitnessed falls.	observations of residents who have sustained unwitnessed falls. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Oceania provide staff education for clinical and non-clinical staff. Review of the required dementia education for HCAs working in the dementia unit was conducted. There was evidence not all HCAs working in the dementia unit have completed the required unit standards within the 18 month timeframe after their appointment.	Not all staff working in the dementia unit have completed the relevant education for dementia care.	Provide evidence all staff who work in the dementia unit have completed dementia training as per the ARRC contract. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.