

# Oceania Care Company Limited - Woburn Rest Home

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## 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:** Woburn Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 3 March 2015 End date: 3 March 2015

**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:** 31

# Executive summary of the audit

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## 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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Woburn Rest Home (Oceania) can provide care for up to 33 residents requiring care at either rest home or dementia level. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the district health board contract.

The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

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

Two of three improvements required at the last certification audit around care planning and infection control have been addressed.

An improvement continues to be required to documentation of resolution of issues when these are raised.

This surveillance audit identified improvements required to ensuring complainants are offered advocacy services, the quality programme, orientation, staff competencies and staffing.

## 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.

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

Staff interviewed were able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and care for the residents. Information regarding the complaints process is available to residents and their family and complaints reviewed were investigated, however information around advocacy services should be provided to complainants. Staff communicate with residents and family members following any incident.

## 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.

Woburn has implemented the Oceania quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and business status reports allow for the monitoring of service delivery. Benchmarking reports are produced that include clinical indicators, incidents/accidents, infections and complaints. An improvement continues to be required to documentation of resolution of issues when these are identified and to analysis of data with corrective actions documented if required.

Staffing levels reviewed were adequate across the service; however use of health care assistants to complete laundry and cleaning tasks while also supporting residents should be reviewed. An improvement is also required to the orientation programme and to ensure that documentation of staff competencies is retained on file.

## 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 at Woburn receive services from suitably qualified and experienced staff. Evaluations reviewed were documented, resident-focused and indicated progress towards meeting the desired outcomes. Where the progress of a resident is different from the expected, the service responds by initiating changes to the person centred care plan. Family have opportunity to contribute to care plans.

Resident files reviewed demonstrated initial care plans, short term care plans for acute conditions and person centred care plans for long term service delivery. Resident, nursing and medical reviews are conducted within the required timeframes. Activities are planned and the programme is provided to residents and family.

At the time of the audit, the medicines management system provided safe processes for prescribing, dispensing, review, storage and disposal of medicines. Medicine management training is conducted annually. The medicines policy includes a section on the self-administration of medicines, however the service did not have any residents who self-administered medicines.

Service providers responsible for medicines management complete annual competencies. Medicines charts reviewed were legible, allergies were identified and controlled drug register entries were in line with legislative requirements. Medicines fridge temperatures are maintained and recorded.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines appropriate to the needs of the residents. Menus are reviewed annually. The cook receives a duplicate of the dietary plan for new residents to ensure dietary needs of the residents are implemented. Kitchen staff complete food safety training.

## 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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At the time of the audit there was a current building warrant of fitness. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family interviewed described the environment as appropriate with indoor and outdoor areas providing an environment that meets their needs. This also includes a secure dementia unit with a suitable outdoor and indoor area for residents.

## 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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Documentation of restraint minimisation and safe practice policies and procedures supports the service to be restraint free.

Systems are in place to ensure assessment of residents is undertaken prior to enabler use, should a resident ever ask to use an enabler. The residents' files reviewed demonstrated that the service focuses on de-escalation processes. All residents in the

dementia unit have 24-hour challenging behaviour management plans to ensure their behaviour is managed in an appropriate manner.

## 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.

Surveillance is appropriate to the size and complexity of the organisation. Documentation reviewed provided evidence that the service has surveillance reporting processes in place. Surveillance results are reported in both areas of service. The registered nurses collate information at monthly intervals and data is recorded as clinical quality indicators on their internal system.

Quality indicators are reported at health and safety, quality improvement, staff meetings and management meetings. The data is collated, displayed in clinical areas and staff have access to surveillance information. Infection control education is provided annually as part of the in-service education programme. Staff members complete annual infection control competencies.

## 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	12	0	3	1	0	0
Criteria	0	36	0	4	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

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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.	PA Low	<p>The organisation's complaints policy and procedures are in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include timeframes for responding to a complaint. Complaint forms were observed to be available in the facility and family and residents interviewed knew where they could get a form.</p> <p>The complaints register in place was reviewed and included 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 complaints folder.</p> <p>Two complaints lodged in 2014 were selected for review. There was documented evidence of time frames being met for responding to these complaints with documentation indicating that the complainants were happy with the outcome. The complainants were not offered advocacy services.</p> <p>Residents and family members interviewed stated that they would feel comfortable complaining.</p> <p>There have not been any complaints with the Health and Disability Commission (HDC) or other authorities since the last audit.</p>
Standard 1.1.9:	FA	Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to

<p>Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>notify family/enduring power of attorney of any accident/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, a change in health or a change in needs as confirmed in a review of six accident/incident forms and in the resident files. Files reviewed demonstrated family contact is recorded. Interviews with family members confirmed they are kept informed. Family are invited at least six monthly to the care planning meetings for their family member as documented in resident files reviewed. Interpreter services are available when required from the district health board. At the time of the audit there were no residents requiring interpreting services and all residents interviewed confirmed that staff were approachable and communicated well. An information pack is available in large print and staff interviewed advised that this could be read to residents. Staff training records evidenced training received around connecting with people and communicating in 2014 with a number of sessions offered during the year to accommodate staff.</p>
<p>Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Woburn is part of the Oceania Care Company Limited with the executive management team including the chief executive officer, general manager, operations manager, regional operational managers and clinical and quality managers providing support to the service. Communication between the clinical and quality manager, the regional operations manager and the business and care manager takes place on a regular basis (at least once a month) with more support provided as required. Oceania has a clear mission, values and goals and staff interviewed were able to describe these. These were observed to be displayed in the foyer of the service. The facility can provide care for up to 33 residents requiring rest home level of care (22 beds available) or dementia level of care (11 beds available). During the audit there were 31 residents living at the facility including 20 residents at rest home level of care and 11 residents at dementia level of care. The business and care manager (registered nurse) responsible for the overall management and clinical care of the facility, has been in the role since April 2014 with over 10 years' experience in aged care. The business and care manager is supported by a registered nurse who provides 32 hours clinical support and oversight particularly of the rest home area.</p>
<p>Standard 1.2.3: Quality And Risk</p>	PA	<p>Woburn uses the Oceania quality and risk management framework that is documented to guide practice. The</p>

<p><b>Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>Moderate</p>	<p>business plan is documented and reporting occurs through the business status reports.</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 Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies were noted to be readily available to staff. New and revised policies are signed by staff to say that they have read and understand them.</p> <p>All staff interviewed reported they were kept informed of quality improvements.</p> <p>At the time of the audit there were monthly meetings that included the following: staff; health and safety; infection control and quality improvement. Minutes of these meetings are documented.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are also in place for the service, which includes a documented hazard management programme and a hazard register for each part of the service. On review of this, there was evidence that any hazards identified were signed off as addressed or risks were minimised or isolated.</p> <p>There is an annual satisfaction survey for residents and family which on review showed a high level of satisfaction.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. Quality improvement data is analysed for some components of the quality programme, however this should be extended to include analysis of other data such as falls analysis and analysis of clinical indicators collected with evidence that this is used to improve service delivery.</p> <p>Corrective action plans are documented, however not all showed evidence of resolution of issues. The improvement required at the certification audit continues.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate</p>	<p>FA</p>	<p>The registered nurse and clinical and quality manager are aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks. There have been no times since the last audit when authorities have had to be notified.</p> <p>The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff records reviewed demonstrated that staff receive education at orientation on the incident and accident reporting process (refer 1.2.7.4). Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Six incident reports selected for review had a corresponding note in the progress notes to inform staff of the incident. There was evidence of open disclosure for each recorded event. Information gathered is regularly shared through the monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with</p>

their family/whānau of choice in an open manner.		other Oceania facilities. Staff interviewed described discussion at meetings around incident and accident data.
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	<p>Human resources policy and processes are in place. All registered nurses hold current annual practising certificates. Current visiting practitioners' practising certificates reviewed were current and included the general practitioners, pharmacists, dietitian, podiatrist and physiotherapist. Staff files randomly selected for audit included employment documentation such as job descriptions, contracts and appointment documentation on file. Police checks were completed and an annual appraisal process is in place with all applicable staff having a current performance appraisal documented in all files reviewed.</p> <p>A comprehensive orientation programme is available for staff to complete orientation on entry to the service that meets the educational requirements of the Aged Residential Care contract. The orientation programme is relevant to the dementia unit. Not all staff files reviewed showed completion of orientation. Staff interviewed were able to articulate the buddy system in place for new staff members and the competency sign off process in place. Mandatory training was identified on an Oceania wide training schedule. A training and competency file is held for all staff, with folders of attendance records and training with a spreadsheet maintained for all training held. The health care assistants stated that they valued the training. Education and training hours exceeded eight hours a year for all staff reviewed. The training register and training signage sheets evidenced staff attendance of annual medication and other competencies such as hoist; oxygen use; hand washing; wound management; moving and handling; restraint; nebuliser; blood sugar and insulin; assisting residents to shower, however, competency sign off documents were not consistently maintained or evidenced in staff files.</p>
Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low	<p>The staffing policy is the foundation for work force planning. Staffing levels were 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. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy, however additional tasks are completed by health care assistants in the morning and this should be reviewed.</p> <p>There is a registered nurse on duty three days a week with time allocated predominantly to the rest home area. The business and care manager is a registered nurse and provides support and oversight of the dementia unit.</p> <p>Residents and families interviewed confirmed that staffing is adequate to meet the residents' needs. Staffing in the dementia unit meets resident needs with all staff having completed training in challenging behaviour, de-escalation and care of residents with dementia.</p> <p>There were 38 staff at the time of the audit including the business and care manager (on leave on the day of the audit), one other registered nurse and 27 health care assistants.</p>

<p><b>Standard 1.3.12:</b> 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 registered nurses reported that prescribed medications are delivered to the facility and checked on entry. The medication areas, including the controlled drug storage area are appropriate, secure, free from heat, moisture and light, with medicines stored in original dispensed packs. A controlled drug register is maintained. Registered nurses complete weekly checks and six monthly physical stock takes are completed by the pharmacists. Medication fridge temperature checks are conducted and recorded.</p> <p>Staff members authorised to administer medicines had received training (refer to 12.7.5). The morning medication round was observed. The staff interviews confirmed staff members were knowledgeable about the medicine administered and signed off. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.</p> <p>Each resident file reviewed had an individual medicines profile and medicine prescription form with an individually dispensed medicines and medicine signing sheet. Medicine charts sampled evidenced residents' photo identification, allergies recorded and legibility. The review of medicines charts demonstrated three monthly medicine reviews were conducted and discontinued medicines were dated and signed by the GPs. At the time of the audit there were no residents who self-administer medicines. There is a policy on self-administration of medication by competent residents.</p>
<p><b>Standard 1.3.13:</b> 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>Food services are delivered in line with legislative requirements. The menu is developed and reviewed by a dietitian. Resident's individual dietary needs are identified, documented and reviewed as part of the nutritional assessment on admission of the resident. The cook is informed when resident's dietary needs change or new residents are admitted with special dietary needs. Additional food and snacks are available for residents.</p> <p>Residents are offered fluids throughout the day. Residents' files sampled demonstrated regular monthly monitoring of individual resident's weight. Residents and relatives interviewed were satisfied with the food service. The fridge and freezer temperature were reviewed and are monitored weekly. Food temperatures are checked at each meal time to ensure the food is serviced at an acceptable temperature.</p> <p>The staff files reviewed evidenced that kitchen staff complete food safety training.</p>
<p><b>Standard 1.3.6:</b> Service Delivery/Interventions</p> <p>Consumers receive</p>	FA	<p>The residents' files reviewed evidenced GP notes, records were current and consultation and liaison was occurring with other services. Interventions documented were based on the assessed needs, desired outcomes or goals of the residents.</p> <p>On observation, there were adequate continence and dressing supplies in accordance with requirements of the</p>

<p>adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>service agreement. In interviews, residents and family confirmed their and their relatives' current care and treatments they were receiving met their needs and their involvement in the care planning process.</p> <p>Review of resident files demonstrated that nursing progress notes and observations charts were maintained. The family communication sheet confirmed communication occurs with family. The previous requirement for improvement relating to interventions to support identified goals, is fully implemented.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>In interview, the activities coordinator (AC) confirmed the activities programme met the needs of the service group. Residents, family and staff interviews confirmed the activities programme included input from external agencies and supported ordinary, unplanned and spontaneous activities that included festive occasions and celebrations. Regular exercises and outings are provided. The residents in both areas of the service were observed to be actively engaged in activities during the on-site visit. Interview with the AC confirmed that resident received monthly activities programmes and have a variety of activities to choose from.</p> <p>The AC is responsible for conducting residents' activities assessments and implementation and evaluation of the activities programme. The activities care plans reviewed were part of the person centred care plans and conducted by the RNs in consultation with the activities coordinator. Residents' activities attendance records are maintained as sighted. The residents' meeting minutes reviewed evidenced residents' involvement and consultation of the planned activities programme.</p> <p>The residents' files reviewed demonstrated the individual activities care plans were current and individualised. All residents in the dementia unit have 24-hour management plans for managing challenging behaviour.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Interviews with staff members and family reported that family are notified of changes in the resident's condition. The communication with family members is recorded in residents' files.</p> <p>Residents' files provided evidence that care plans are evaluated every six months, or sooner when the resident's condition required. Evaluations are conducted by the registered nurses (RN) with input from the resident, family, care and activity staff. Multidisciplinary reviews sighted were current. When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans are used when required.</p> <p>Time frames in relation to care planning evaluation are documented. There was recorded evidence of additional input from professionals, specialist or multi-disciplinary sources, if this was required. The residents' files evidenced referral letters to specialists and other health professionals. Updated care plans reflect changes in the condition of residents.</p>

<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 17 March 2015). There have been no building modifications since the last audit.</p> <p>A planned maintenance schedule is implemented and the maintenance staff confirmed implementation of this.</p> <p>The lounge areas are designed so that space and seating arrangements provided for individual and group activities and all areas are suitable for residents with mobility aids.</p> <p>The following equipment was available at the time of the audit: pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. A test and tag programme is in place. Equipment is calibrated.</p> <p>On observation, it was noted that there were safe external areas for residents and family to meet/use and these included paths, seating and shade.</p> <p>The dementia unit has appropriate furnishings with a secure unit and outdoor area.</p>
<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organization. Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators on the intranet.</p> <p>Residents with infections have short term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on monthly at staff, quality, and infection control and health and safety meetings. Interviews confirmed information relating to infections is made available for clinical staff during hand over and at staff meetings.</p> <p>The previous requirement for improvement relating to feedback on infections to be included in staff meetings, is fully implemented.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler is congruent with the definition in the Standard. The registered nurse interviewed confirmed that the service does not use restraint or enablers. There was no evidence of restraint or enabler use on the day of the on-site audit. Staff confirmed that they are aware of the approval process for enabler use and that enabler use has to be voluntarily and requested by the enabler user.</p> <p>The restraint coordinator conducts education and training on restraint minimisation and safe practice. De-escalation techniques are used for management of challenging behaviour. All residents in the dementia unit had 24-hour challenging behaviour management plans to guide staff in the management of behaviours that challenge.</p>



## Specific results for criterion where corrective actions are required

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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 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	Two complaints were documented on the complaints register for 2014. The business and care manager had signed these off with evidence that the complainant had agreed with the result.	The complainant was not offered advocacy services should they wish to have independent support.	Offer advocacy services to the complainant when complaints are raised.  90 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	PA Moderate	There is a policy around documentation of corrective actions and management of issues raised. Staff interviewed including the registered nurse and the clinical and quality manager understood the process of documenting corrective actions and resolution of issues.  On review, there was some	i) Resolution of issues raised such as those raised through internal audits are not always documented. The improvement required at the previous certification audit remains. ii) Data is not always analysed with corrective action plans documented and evidence that information is used to improve services. This is a new finding identified at this audit.	i) Document evidence of resolution of issues. ii) Analyse data and document corrective action plans with evidence that information is used to improve services.  180 days

implemented.		<p>documentation of resolution of issues when identified in internal audits, surveys and complaints.</p> <p>Review of the data collected demonstrated documentation of the analysis of falls, a graph that identifies the proportion of residents at different levels of nutritional risk and other information collected in clinical indicator reports on a monthly basis that could be used to improve services.</p>		
<b>Criterion 1.2.7.4</b> New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	<p>There was a policy and processes for staff to complete orientation on entry to the service. Two of six staff files reviewed had a completed orientation on file.</p> <p>The health care assistants stated that they buddied new staff and supported them to complete competencies prior to the new staff member working with residents by themselves.</p>	Of the six staff required to have a documented orientation, four did not have documented evidence of completed orientation in staff files	Ensure that a record of orientation is documented and a copy held on the staff file.  180 days
<b>Criterion 1.2.7.5</b> A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to	PA Low	<p>There was a policy documented around training including completion of competencies and compulsory training days for staff. An annual training plan was documented for 2015.</p> <p>There were attendance records kept which included signatures of staff attending the training along with the</p>	The service could not consistently locate or track documented evidence of all required competencies in each staff file that included staff signatures of those verifying competency on the day of the audit.	Consistently include documentation that verifies competency of the staff member.  180 days

		<p>consumers.</p> <p>content of the programme and date of the workshops.</p> <p>There was a log of competencies documented that included names of staff who had completed competencies.</p> <p>There was evidence in the staff files reviewed of some competencies signed off by the staff member being observed and the observer.</p>		
Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Low	<p>Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy with staff replaced when on leave.</p> <p>At the time of the audit, on the morning shift, one health care assistant also completes cleaning duties, while the other completes laundry. While, they are able to answer bells, individual care and support needs may be compromised.</p> <p>A health care assistant is rostered overnight with duties including laundry and cleaning. The registered nurse interviewed stated that the cleaning and laundry duties were only meant to be completed by the health care assistant on the night duty who had a job description describing the role.</p> <p>Staff, residents and family interviewed confirmed that there were sufficient staff on duty.</p>	<ul style="list-style-type: none"> <li>i) Health care assistants may not be able to provide timely individual support and care if they are both completing laundry and cleaning tasks.</li> <li>ii) If laundry and cleaning tasks are completed on night duty, may disturb resident sleep and rest.</li> </ul>	<ul style="list-style-type: none"> <li>i) Ensure that there are sufficient staff on duty in the rest home who can support residents at all times on the morning shift. ii) Provide laundry and cleaning duties at a time that suits resident's activities of daily living/sleep patterns</li> </ul> <p>60 days</p>

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## **Specific results for criterion where a continuous improvement has been recorded**

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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 audit.

No data to display

End of the report.