

# Oceania Care Company Limited - West Harbour Lodge

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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:** West Harbour Lodge

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 12 October 2015      End date: 12 October 2015

**Proposed changes to current services (if any):** As per the HealthCERT letter, this audit has verified one room with two beds as being able to provide hospital level care with the numbers of hospital beds identified as 51. The total bed number has increased from 68 to 70.

**Total beds occupied across all premises included in the audit on the first day of the audit: 57**



# 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

Indicator	Description	Definition
Yellow	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
Red	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

West Harbour Lodge (Oceania) can provide care for up to 70 residents requiring care at either rest home or hospital level with an occupancy of 57 on the day of audit. 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. This audit has confirmed that a room is able to provide hospital beds for two residents. This has taken the number of beds available in the service from 68 to 70.

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.

All improvements required at the last certification audit to the quality programme, care planning, the activities programme around planning and administration of medication have been addressed.

This surveillance audit identified improvements required to documentation of family and resident involvement in care planning and to the activities programme including a programme for residents under the age of 65 years and review of activities plans.

## 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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Staff interviewed are 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 with documentation completed and stored in the complaints folder. 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.		Standards applicable to this service fully attained.
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West Harbour Lodge 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 include clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented. Corrective action plans are documented with evidence of resolution of issues when these are identified.

Staffing levels are adequate across the service, with human resource policies implemented. There are no staffing changes required with the addition of the two hospital beds.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a guide for all staff while the long term care plan is developed over the first three weeks of admission. Person centred care plans are reviewed every six months, are individualised and risk assessments are completed. Residents' response to treatment is evaluated and documented. Relatives are notified regarding changes in a resident's health condition.

Activities support residents' interests and strengths. The residents and families interviewed expressed satisfaction with the activities provided by the diversional therapist.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. The general practitioner completes medical reviews of residents and medicines. Medication competencies are completed annually for all staff that administer medications.

The facility utilises four weekly rotating summer and winter menus reviewed by a dietitian.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is 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 describe the environment as meeting their needs with indoor and outdoor areas that have seating and shade. Areas have been refurbished throughout the site. A previous meeting room has been converted to one room and able to accommodate two hospital beds, with this confirmed as fit for purpose during the 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 restraint minimisation programme defines the use of restraints and enablers. The restraint register is current. Policies and procedures comply with the standard for restraint minimisation and safe practice. Restraint assessment, documentation, monitoring, maintaining care, and reviews are recorded and implemented. Residents using restraints had no restraint-related injuries.

## 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.
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The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. Staff education in infection prevention and control is conducted according to the education and training programme and recorded in staff files.

Infections are investigated and appropriate antibiotics are prescribed according to sensitivity testing. The surveillance data is collected monthly for benchmarking. Appropriate interventions are in place to address the infections. There are adequate sanitary gels and hand washing facilities for staff, visitors and residents. Staff members were able to explain how to break the chain of infection.

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	14	0	2	0	0	0
<b>Criteria</b>	0	39	0	2	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<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 are available in the facility and family and residents interviewed know where they can get a form. Two family members described a complaint and they stated that the family were satisfied with the outcome of the complaint.</p> <p>The complaints register in place 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 complaints folder.</p> <p>Two complaints lodged in 2015 were selected for review. There is documented evidence of time periods being met for responding to these complaints with complainants happy with the outcome in each case. Documentation for each complaint on file indicates that each complaint is thoroughly investigated with letters on file to confirm that complainants have been informed of receipt of the complaint and the outcome with any staff involved documenting actions taken. Documentation includes staff signatures, names and designations.</p> <p>There has been one complaint lodged with the Health and Disability Commission (HDC) since the last audit. The Health and Disability Commissioner letter confirms that there are no actions required in response to the complaint. There have been no other complaints lodged by other agencies.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Accidents/incidents - the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accidents/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is available.</p> <p>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 accident/incident forms and in the resident files.</p> <p>Files reviewed include documentation around family contact (refer to 1.3.6). Interviews with family members confirm they are kept informed. Family confirm that they are invited at least six monthly to the care planning meetings for their family member.</p> <p>Interpreting services are available when required from the district health board. The business and care manager stated that families are involved in resident care and can interpret when required. At the time of the audit, there was one resident requiring interpreting services for specific tasks and family interpret on a day-to-day basis for them. A family member interviewed stated that the resident who did not speak English was well supported by staff on each shift.</p> <p>All residents interviewed confirm that staff are approachable and communicate well with them.</p> <p>An information pack is available in large print and staff interviewed advised that this could be read to residents.</p> <p>Staff training records include annual training around connecting with people and communication.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>West Harbour Lodge is part of the Oceania Care Company Limited with the executive management team including the chief executive officer, general manager, operations manager, regional operational manager and regional clinical and quality manager providing support to the service.</p> <p>Communication between the regional 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.</p> <p>Oceania has a clear mission, values and goals and the staff interviewed were able to describe these. These were observed to be displayed in the foyer of the service.</p> <p>The facility can provide care for up to 70 residents requiring rest home or hospital level of care (noting that two hospital beds were verified as being suitable thus taking the total of hospital beds from 49 to 51 on the day of the audit). During the audit there was an occupancy of 57 residents.</p> <p>The business and care manager is responsible for the overall management of the facility and has been in the role for seven months. The business and care manager has been in management of aged care services for 17 years.</p>

		The business and care manager is supported by a clinical manager (registered nurse) who has been in the role for 10 months.
<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>West Harbour Lodge uses the Oceania quality and risk management framework, that is documented, to guide practice. The business plan is documented and reporting occurs through the business status reports. These include: financial monitoring; review of staff costs; progress against the healthy workplace action plan; review of complaints/incidents; relationships and market presence action plan and review of physical products.</p> <p>The service implements 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 are readily available to staff and new and revised policies are signed by staff to say that they have read and understand them.</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 and corrective action plans are documented with evidence of resolution of issues. The previous requirement related to documentation of resolution of issues has been addressed.</p> <p>There are monthly meetings, with minutes documented, that include the following: management; health and safety; restraint and quality/staff. Clinical (registered nurse) meetings are held four weekly, with resident and family meetings held monthly.</p> <p>All staff interviewed report that 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 and there is a documented hazard management programme and a hazard register. Any hazards identified are signed off as addressed or risks are minimised or isolated.</p> <p>There is an annual satisfaction survey for residents and family. The survey completed in 2015 indicates that residents and family are satisfied or very satisfied with care and support provided. The recommendations identified as a result of the survey have been completed with improvements implemented.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	FA	<p>The business and care manager, and clinical 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. Times when authorities have had to be notified are documented and retained on the relevant file. This includes notification of the new clinical manager to HealthCERT.</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 demonstrate that staff receive education at orientation on the</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>incident and accident reporting process. Staff interviewed understand the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities.</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>	<p>FA</p>	<p>Human resource policy and processes are in place. All registered nurses hold current annual practising certificates. Current visiting practitioners' practising certificates reviewed are current and include the general practitioners, pharmacists, dietitian, podiatrist and physiotherapist. 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>A comprehensive orientation programme is available for staff. The programme has been reviewed and staff state that there is improved satisfaction with the orientation process. Preceptors are appointed and there is a longer time given for new staff to complete orientation. Staff files show completion of orientation. Staff are able to articulate the buddy system in place and the competency sign off process completed.</p> <p>Mandatory training is 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 electronic documentation of all training held. 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 such as: medication; restraint; infection control; health and safety; manual handling and continence. Registered nurses have an hour of training at each meeting that includes relevant topics such as: pain management; complaints management; nutrition; assessments; medication administration and falls. The training register and training attendance sheets show staff completion of annual medication and other competencies, such as: hoist; oxygen use; hand washing; wound management; moving and handling; restraint; nebuliser; blood sugar and insulin.</p> <p>Education and training hours exceed eight hours a year for all staff reviewed. Health care assistants have completed level three or four training around aged care. The health care assistants state that they value the training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	<p>FA</p>	<p>The staffing policy is the foundation for work force 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. Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy. Rosters were checked to ensure that residents requiring either hospital or rest home level of care were well supported according</p>

<p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>to individual need. Evidence reviewed and observations confirmed that residents requiring hospital level of care were well supported with a registered nurse on duty at all times. Residents requiring rest home level of care are encouraged to be as independent as possible and there is a registered nurse on duty for rest home residents in the morning.</p> <p>Residents and families interviewed confirm that staffing is adequate to meet the residents' needs.</p> <p>There were 72 staff at the time of the audit including: the business and care manager; the clinical manager; registered nurses and health care assistants. Household staff are appointed. The clinical manager or a designated registered nurse is on call at any given time.</p> <p>There are no changes to staffing required with the addition of the two hospital beds.</p>
<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>	<p>FA</p>	<p>Medicine management policies and procedures are in place and implemented and include processes for safe and appropriate prescribing, dispensing and administration of medicines. The medication areas are free from heat, moisture and light, with medicines stored in original dispensed packs, in a secure manner. Medicine charts listed all medications the resident was taking, including name, dose, frequency and route to be given. Charts are signed by the GP. All entries are dated and allergies recorded. All residents have photo identification. Discontinued medicines are signed and three monthly GP reviews are completed within the three monthly timeframe. Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored daily. Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. Sharps bins were sighted. Unwanted or expired medications are collected by the pharmacy. Medication administration was observed during lunch time in the hospital. The staff member checked the identification of the residents, completed cross checks of the medicines against the script, administered the medicines and then signed off after the resident took the medicines.</p> <p>Staff were authorised to administer medications. This requires completion of medication competency testing, in theory and practice. All staff members responsible for medicines management complete annual competencies. Self-administration of medicine policies and procedures are in place. There were two residents who self-administered their own medication in the form of inhalers. Medicines management training occurs for staff.</p> <p>The previous requirement for improvement relating to staff needing to use appropriate documentation/guidelines when crushing medicines is implemented.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>The food service policies and procedures are appropriate to the service setting with seasonal menus reviewed by a dietitian. Residents' dietary profiles are developed on admission and reviewed six monthly or when a resident's condition alters. There are current residents' dietary profiles in residents' files and copies in the kitchen. The kitchen staff are informed if resident's dietary requirements change. Interviews with kitchen staff confirm their awareness of</p>

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>the residents' dietary requirements. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Residents who require special eating aids are provided for to promote independence.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weight. Supplements are provided to residents with identified weight loss. In interviews, residents stated they are satisfied with the food service, reported their individual preferences are met and adequate food and fluids are provided. The residents' meeting minutes' evidence feedback about the food service is positive.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Residents' receive adequate and appropriate services meeting their assessed needs and desired outcomes (refer to 1.3.7.1). Interventions are documented for each goal in the person centred care plans. Interview with the GP confirmed clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long term care plans such as: the speech language therapist; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist.</p> <p>Multidisciplinary meetings are conducted to discuss and review long term care plans. Four out of five residents' files did not reflect the residents and family involvement in the development of goals and review of care plans. There is a requirement for improvement relating to all resident person centred care plans (PCCP) to be signed by the resident or their family to confirm their contribution to the PCCP.</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>	<p>PA Low</p>	<p>The activities programmes confirm that independence is encouraged and choices are offered to residents. The diversional therapist (DT) coordinates the activities programmes. The service had three residents under the age of 65 at the time of the audit.</p> <p>Activities include: physical; mental; spiritual and social aspects of life to improve and maintain residents' wellbeing. During the onsite visit, activities included residents going for an outing, music and one-on-one activities. Residents and family confirmed they were satisfied with the activities programme.</p> <p>On admission, the DT completes a recreation assessment for each resident. The recreation assessments include personal interests, family history, work history and hobbies to ensure resident's participation in the activities. The previous requirement for improvement relating to residents' having activity plans is implemented however a new finding was raised. Not all residents' files reviewed during the onsite audit had six monthly activity reviews consistently completed and residents under the age of 65 did not have additional activities to ensure their specific needs, especially social needs, are met.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents' files reviewed showed long term care plans had six monthly reviews completed. Clinical reviews are documented in the multidisciplinary review (MDR) records, which include input from: the GP; RNs; health care assistants; the DT and other members of the allied health team. Daily progress notes are completed by the health care assistants and RNs. Progress notes reflect daily response to interventions and treatments.</p> <p>Residents are assisted in working towards goals. Short term care plans are developed for acute problems for example: infections; wounds; falls and other short term conditions.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date December 2015). A meeting room has been converted into a bedroom and a couple requiring rest home care are now in the room. One of the residents interviewed confirmed that the room is suitable for the purpose. There is a deck off the bedroom with a fence around the deck. The stairs off the deck have a handrail and gate.</p> <p>A planned maintenance schedule is implemented and the maintenance staff and documentation confirmed implementation of this.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids.</p> <p>Equipment relevant to care needs is available and staff confirm that there is always sufficient. A test and tag programme is in place. Equipment is calibrated.</p> <p>There are safe external areas for residents and family to meet/use and these include paths, seating and shade.</p>
<p>Standard 3.5: Surveillance</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>	<p>FA</p>	<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 Oceania 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 responsibility for the surveillance programme is that of a senior registered nurse. Information gathered was clearly documented in the infection log and maintained by the infection control coordinator. The infection control coordinator (ICC) collects infection control data and collates the surveillance data for benchmarking. The infection control surveillance register includes monthly infection logs and antibiotics use. The organisation has an internal benchmarking system.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Staff interviewed, observations, and review of documentation demonstrated that the use of restraint is actively minimised. Restraints used in the facility include lap belts and bedrails. There were two residents using restraints and one resident using an enabler on the day of the on-site audit. The files reviewed for restraint and enabler use showed enabler use was voluntary and the least restrictive option for the resident. Residents who used restraints had risk management plans in place. The restraints were documented in their person centred care plans. There were no restraint related injuries reported.</p> <p>The service has a documented system in place for restraint use, including a current restraint register. Reasons for restraint use were considered and documented in the restraint assessments. The restraint coordinator is the clinical manager (CM).</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)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Five resident files were reviewed and four out of five residents' person centred care plans did not show evidence of the resident or their family contributing to the PCCP.	Four of five resident person centred care plans were not signed by the resident or family members.	<p>All person centred care plans to be signed by the resident or their family to confirm their contribution to care planning.</p> <p>180 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the</p>	PA Low	Five residents' files were reviewed for six monthly activities assessments and reviews by the DT. Two of the five files did not have six monthly reviews of activities completed. The activities programme addresses the needs of hospital and rest home level residents but does not specifically address the social and other specific needs of residents under the age of 65.	i) Two out of five residents' files reviewed did not have six-monthly reviews of activities completed and ii) the activities programmes did not include additional activities for residents under the age of 65.	i) All residents' activity assessments to be reviewed at six monthly intervals and ii) the activities programmes to facilitate additional activities for residents under 65.

consumer.				90 days
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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 of this audit.

No data to display
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End of the report.