

# Oceania Care Company Limited - Takanini 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:**

**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: 10 March 2016 End date: 11 March 2016

**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:** 84

# 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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Takanini Lodge (Oceania) can provide care for up to 91 residents requiring care at either rest home, dementia or hospital level with 84 residents 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.

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 the regional and executive management team. Service delivery is monitored.

This surveillance audit identified improvements required to the following: signing off adverse event forms; dating of initial care plans; staff designation in progress notes; intervention on long term and short term care plans and activities assessments.

## 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 including the complaints process. Information regarding the complaints process is available to residents and their family. Complaints reviewed are investigated with documentation completed and stored in the complaints folder. Staff communicate with residents and family members following any incident with this recorded in the resident's file. Residents and family state that the environment is conducive to communication including identification of any issues.

## 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 low risk.
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Takanini Lodge has documentation of 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 at times of resolution of issues when these are identified.

Staffing levels are adequate across the service with human resource policies implemented. This includes evidence of recruitment and staffing. Rosters indicate that staff are replaced when on leave.

Improvements are required to review of incident forms by the clinical manager or the business and care manager.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents have initial care plans developed on admission and the person centred care plans are developed within three weeks of admission. Residents admitted after July 2015 have InterRAI assessments completed. The service uses short term care plans for acute problems. The residents and family interviewed confirmed their input into care planning and access to a range of life experiences and choices. Sampling of residents' clinical files evidences six monthly nursing reviews. There are requirements for improvement relating to care planning and progress notes.

The residents and family interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis, however there is a requirement for improvement relating to recreational assessments to be fully completed.

Medication areas, including controlled drug storage, evidence a secure medicine dispensing system. Review of staff competencies confirmed all staff have current medication management competencies. Three residents were self-administering some of their medicines. Self-administration of medicines occurs according to policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. There is a central kitchen and on site staff that provide the food service. The kitchen staff have completed 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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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 appropriate with indoor and outdoor areas that meet their needs. There is a secure dementia unit that includes indoor and outdoor areas.

## 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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Restraint minimisation policy and procedures are congruent with the restraint minimisation and safe practice standard. Documentation of restraints and enablers included identification of risks and monitoring time-frames. There is a job description for the restraint coordinator and the service is maintaining a restraint register.

## 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.

The infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. Staff are familiar with infection control measures and the use of personal protective equipment.

The infection control surveillance programme is appropriate for the size and complexity of the services provided. The infection control coordinator has a signed job description and is responsible for staff education in infection 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)
<b>Standards</b>	0	12	0	3	1	0	0
<b>Criteria</b>	0	37	0	3	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)
<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>	FA	<p>The organisation's complaints policy and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes periods for responding to a complaint. Complaint forms are available in the facility.</p> <p>A complaints register is in place and the register 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. Two complaints tracked indicate that all timeframes taken to inform the family and resolve the issues raised are met as per the policy.</p> <p>Two family members stated that they had made a complaint and both stated that their complaint had been dealt with promptly and to their satisfaction. Both complaints were documented on the complaints register.</p> <p>Residents and family members all state that they would feel comfortable complaining.</p> <p>There have been two complaints forwarded by the Health and Disability Commission since the previous audit. Both were lodged in 2015. The Health and Disability Commissioner's office has responded with a request for further information for one complaint and the other has been closed out with no actions required.</p>
Standard 1.1.9:	FA	Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>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>If the resident has an incident, accident, a change in health or a change in needs, then family are informed, as confirmed in a review of accident/incident forms and documentation in the residents' files.</p> <p>Files reviewed include documentation around family contact. Interviews with family members confirm they are kept informed. Family confirm that they are invited, at least six monthly, to 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 states that families are involved in resident care and can interpret when required. There were no residents requiring interpreting services at the time of the audit. All residents interviewed confirm that staff are approachable and communicate in a way that meets their needs. The business and care manager has an open door policy that allows residents, family and staff to communicate any issues at any time.</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 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>Takanini Lodge is part of the Oceania Care Company Limited with the executive management team including chief executive officer and general manager. The regional operations manager and clinical and quality manager provided support to the service on the day of the audit. 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.</p> <p>Oceania has a clear mission, values and goals and staff interviewed are able to describe these. These are displayed in the service.</p> <p>The facility can provide care for up to 91 residents requiring rest home, dementia or hospital level of care. There are 22 rest home beds, 48 hospital level beds and 21 dementia beds (approval from the district health board is in place). During the audit, the occupancy was 84, that is 22 residents requiring rest home level care (10 of which are identified as dual purpose beds with all being filled with residents requiring rest home level care on the days of audit), 20 residents requiring dementia level care and 42 residents requiring hospital level care. One resident is under 65 years of age.</p> <p>The business and care manager has been with the service for 10 years with 16 years' experience as either a business and care manager or clinical manager. The business and care manager is a registered nurse with a postgraduate diploma in business administration in management, masters of management and diploma in facility management. The clinical manager provides clinical oversight of the service.</p>

<p><b>Standard 1.2.3: Quality And Risk 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>FA</p>	<p>Takanini 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 and a monthly summary completed by the business and care manager and clinical manager. This includes 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 and 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. The policy around pressure injuries has been reviewed in 2016 and has been read by all staff as confirmed by the business and care manager interviewed.</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 through meetings and benchmarking and corrective action plans are documented. There is evidence of analysis and discussion of data and documentation of evidence of resolution of issues.</p> <p>There are monthly meetings with minutes documented that include the following: management; health and safety; staff; quality; registered nurse; senior team meetings and others as required. There are monthly resident and family meetings. All staff interviewed report that they are kept informed of quality improvements and are able to have input into the quality programme.</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 an annual health and safety plan implemented and monitored. There is a documented hazard management programme and a hazard register for each part of the service. Any hazards identified are signed off as addressed or risks are minimised or isolated.</p> <p>There is a six monthly satisfaction survey for residents and family. The survey completed in 2015 indicates that residents and family are satisfied with the service overall.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are</p>	<p>PA Low</p>	<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, and sentinel events around pressure injuries, critical incidents and infectious disease outbreaks. Times when authorities have had to be notified are documented and retained on the relevant file. The Ministry of Health and district health board have been informed of a coroner's inquest for one resident, with no actions required by the coroner.</p> <p>The service is committed to providing an environment in which all staff are able and encouraged to recognise and</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>report errors or mistakes. Staff records reviewed demonstrate that staff receive education at orientation on the 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>A manager (either the business and care manager or the clinical manager) is expected to sign the incident form to indicate review.</p> <p>An improvement is required to signing off of the incident forms by the manager to indicate review.</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. Criminal vetting is completed and an annual appraisal process is in place with all staff files reviewed having a current performance appraisal on file. A spreadsheet is kept of the dates of performance appraisals completed.</p> <p>A comprehensive orientation programme is available for staff. Staff files show completion of orientation. Staff are able to articulate the buddy system in place and the competency sign off process completed. A new staff member interviewed states that they have had an orientation that included reading of policies and procedures, introduction to residents, staff and to the Oceania processes and buddying on all shifts.</p> <p>Mandatory training is identified on a training schedule. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training held. 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 training from the district health board that includes relevant topics such as: pain management; wound management; nutrition; medication administration and falls. There are four registered nurse trained to complete InterRAI assessments, including the clinical manager. 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. Staff have completed training around pressure injuries in May and July 2015 and in March 2016. Education and training hours exceed eight hours a year for all staff reviewed. The health care assistants state that they value the training.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<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 reflect staffing levels that meet resident acuity and bed occupancy. Rosters indicate that residents requiring either dementia, hospital or rest home level of care are supported by an adequate number of staff on duty at any given time.</p> <p>There is a registered nurse on duty at all times. The roster has been reviewed in October 2015 to increase the number of registered nurses during the days when there are doctor's rounds and during the weekends to enable family members time to discuss any concerns with a registered nurse.</p> <p>Residents and families interviewed confirm that staffing is adequate to meet the residents' needs during the weekdays. The same staffing model is applied at weekends.</p> <p>There were 77 staff at the time of the audit, including the business and care manager and the clinical manager. Household staff are appointed and include cleaners who provide seven day a week cleaning and kitchen staff who provide seven day a week food preparation and cooking. There are activities staff including staff designated to work specifically in the dementia unit. There are 13 registered nurses employed in the service.</p> <p>There is an equal mix of rest home and hospital level of care in all areas in the service and staff are given an equal mix of rest home and hospital residents to care for. Staff also work in pairs and as a team to ensure that hospital residents are given appropriate care and support relative to their needs. There are always two staff for example, when using a hoist, as described by staff interviewed and as observed on the day of audit.</p> <p>Staff are allocated specifically to the dementia unit. All staff working in the dementia unit have completed training around dementia apart from two new staff who are always supervised by a senior health care assistant or registered nurse. There is a registered nurse who provides oversight for care in the dementia unit.</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>Medication areas, including controlled drug storage evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stock takes by the pharmacist. The medication fridge temperatures are conducted and recorded.</p> <p>Current medication competencies for staff who administer medicines were sighted. The medication round was observed and evidenced the staff member was knowledgeable about the medicines administered and signed off, as the dose was administered. Administration records and specimen signatures are maintained. Medical and medicines reviews by the GP were up to date.</p> <p>Medication audits have been conducted and corrective actions are implemented following the audits. There were three residents self-administering medicines (mainly eye drops and nasal sprays) at the facility and this was</p>

		conducted according to policy.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Interview with the cook confirmed kitchen staff have completed food safety training, and this was verified by food safety certificates. In interview, the cook confirmed residents' individual dietary needs are identified on admission of the resident. The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service and reported their individual preferences are met and adequate food and fluids are provided. On inspection, the kitchen environment was clean, well lit and uncluttered. There was evidence of kitchen cleaning schedules, signed off as cleaning is completed. Fridge, chiller and freezer temperatures are monitored regularly and recorded, as are food temperatures.</p> <p>There is a seasonal menu, last reviewed by a dietitian in August 2015. Review of residents' files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as special diets, pureed meals along with alternative nutrition appropriate to the residents are available. There was enough stock to last in an emergency situations, for three days, for residents and staff.</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>	PA Moderate	<p>The residents' care plans evidence desired outcomes or goals of the residents, however it did not consistently show required interventions. The GP documentation and records are current. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained (refer to 1.3.3.3). In interviews, staff confirmed they are familiar with the current interventions of the resident they are allocated. Short term care plans were sighted in some of the residents' files, and these are used when required (refer to 1.3.3.3).</p> <p>There is a requirement for improvement relating to interventions not being appropriate for all person centred care plans (PCCPs) and short term care plans.</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,</p>	PA Low	<p>The service employs an activities coordinator (AC) who, with oversight of a qualified diversional therapist (DT) is responsible for residents' activities. In interview with the AC, they confirmed the activities programme is available to all residents in the rest home, the hospital and the dementia unit, sighted a copy of the programme. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations.</p> <p>Not all the residents' files reviewed had fully completed activities assessments. Activities care plans in the residents' files reviewed had intervention relating to the activities goals. The residents' activities attendance records are maintained, as are activities progress notes. There is a requirement for improvement relating to activity assessment to be fully completed.</p>

and the setting of the service.		
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' progress records are entered on each shift. When resident's progress is different than expected, the RN contacts the GP, as required. The family are notified of any changes in resident's condition, confirmed at family interviews. There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</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>	FA	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date February 2017). There have been no building modifications since the last audit.</p> <p>A planned maintenance schedule is implemented and the maintenance staff and documentation confirm implementation of this. There is also reactive maintenance with the maintenance staff prioritising any issues daily. There is documented evidence of resolution of any maintenance issues.</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. There is a separate lounge and dining area for residents in the dementia unit and a secure outdoor area that encourages residents to engage in activities.</p> <p>Equipment relevant to care needs is available and staff confirm this is 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. The dementia unit is secure.</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</p>	FA	<p>Documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organisation. 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 ( refer to 1.3.6.1). 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 infection control coordinator (RN) is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at staff meetings (refer to 1.2.3.6).</p>

control programme.		Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files. In interview, the ICC confirmed no outbreak had occurred at the facility since last audit.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and use is recorded. Restraint and enabler use is documented in residents' care plans. There is a job description for the position of the restraint coordinator. The restraint register is maintained. The service had five restraints and no enablers in use at the time of the on-site audit.

## 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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>A manager (either the business and care manager or clinical manager) is expected to sign the incident form to indicate review. Twelve of the sixteen incident forms reviewed included sign off by a manager indicating that they had been reviewed. The incidents are recorded in the clinical indicator report.</p>	<p>Four of sixteen incident forms reviewed have not been signed by a manager.</p>	<p>Ensure that the business and care manager or the clinical manager signs each incident form indicating their review of the incident.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Stages of service provision including assessment, planning care, evaluation and review are provided. Initial care plans are completed on admission, however, timeframes for initial care planning could not be established due to initial care plans not being dated.</p>	<p>i) Four of seven initial care plans were not dated and timeframes for initial care and assessment could not be determined.</p> <p>ii) Progress notes do not consistently show designation of registered nurses and health care</p>	<p>Provide evidence:</p> <p>i) All initial care plans to be dated.</p> <p>ii) Progress notes to show the designation of the person making the entry.</p> <p>iii) Progress notes to show evidence of the outcomes of</p>

			<p>assistants.</p> <p>iii) Progress notes do not consistently show evidence of controlled drug outcomes being recorded or that the outcomes of interventions relating to challenging behaviour are recorded.</p>	<p>specific interventions, for example, a) controlled drug administration and b) the outcomes of interventions relating to the management of challenging behaviour.</p> <p>90 days</p>
<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>	<p>PA Moderate</p>	<p>Six of the seven PCCPs reviewed had interventions to support desired outcomes and one of three short term care plans reviewed included appropriate interventions.</p>	<p>i) One of the seven PCCPs did not have interventions recorded for goals indemnified during the assessment process.</p> <p>ii) Two of three short term care plans did not have appropriate interventions recorded.</p>	<p>i) All goals in the PCCPs to have appropriate interventions to support achieving these goals.</p> <p>ii) All short term care plans to include interventions that support the short term goals.</p> <p>60 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 consumer.</p>	<p>PA Low</p>	<p>Five of the seven resident files reviewed had activity assessments completed for the residents.</p>	<p>Two of the seven resident files reviewed did not have the residents' past and present activities recorded.</p>	<p>All activity assessments to be fully completed, including their past and present activities.</p> <p>180 days</p>

## 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.