

# Oceania Care Company Limited - Eldon Lodge

---

## 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:** Eldon Rest Home

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

**Dates of audit:** Start date: 26 May 2016 End date: 27 May 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:** 116

# Executive summary of the audit

---

## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

## General overview of the audit

This surveillance audit was undertaken to monitor compliance with the Health and Disability Service Standards and the district health board contract. Eldon Rest Home is operated by the Oceania Care Company limited.

The service provides care for rest home, hospital and dementia level of care. Occupancy on the days of audit was 116 residents. The audit process included review of policies and procedures, sampling of resident and staff files, observations and interviews.

The previous requirement for improvement relating to food services was implemented.

There are requirements for improvement relating to adverse event records, wound management and medication management.

## 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.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights information (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, was available. This information is given to residents' and their families on admission to the facility. The business and care manager is responsible for management of all complaints. Interviews confirmed that staff are polite and respectful of residents needs and communication is appropriate.

## 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.
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------------------------

Oceania Care Company Limited is the governing body and is responsible for the service provided at Eldon Rest Home. The business and care manager is appropriately qualified and experienced. The clinical manager is responsible for oversight of clinical care. Quality improvement data is collected, collated, analysed and reported through the use of their national quality system, however there is a requirement for improvement relating to signing off adverse event records. The service has policies and procedures that are aligned with current good practice. The service has a document control system to manage all their policies and procedures. Key quality indicators are included in the quality management system. The service has a quality management plan, including risks and hazard management. Corrective action plans are in place to address areas requiring improvement. Risks are addressed and communicated to residents, their families and staff.

Adverse events are documented and discussed with residents and/or their family. The service provider understands their statutory obligations regarding essential notification. Service shortfalls are documented and opportunities for improvement are identified.

There are human resource policies implemented relating to recruitment, selection, orientation and staff training and staff development. Professional qualifications are validated and registration with professional bodies is verified. A documented rationale for determining staffing levels and skill mix is implemented to reflect the resident's acuity to ensure the correct allocation of clinical

staff is applied. The service has an annual training plan to ensure ongoing training and education for all staff members. The service is currently training additional staff relating to interRAI assessments. The business and care manager and clinical manager are available, after hours, if required, for clinical support. Care staff, residents and family report that there is adequate staff available.

## 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 medium or high risk and/or unattained and of low risk.</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-----------------------------------------------------------------------------------------------------------------------------------

Residents' needs are assessed on admission by a registered nurse. Residents' needs, goals and outcomes are recorded in residents' care plans. The care plan evaluations are conducted on a regular basis. Residents and families interviewed report being informed and involved, and satisfied with services provided.

Activities programmes provide a wide range of activities and involvement with the wider community.

The medicine management policies and procedures guide practice. Medication charts comply with legislation and guidelines.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines. Residents' special dietary requirements, need for feeding assistance or modified equipment are met. Resident interviews verified satisfaction with meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

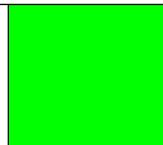


Standards applicable to this service fully attained.

The facility provides a suitable physical environment specific to the needs of the residents. The building and equipment complies with legislative requirements. The physical environment reduces risks and promotes safety and independence for residents. Residents are provided with accessible and safe external areas. The service has a current building warrant of fitness, expiring in April 2017.

## Restraint minimisation and safe practice

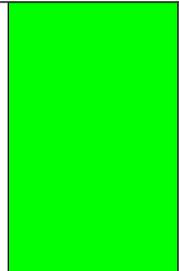
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. Staff education in restraint, de-escalation and challenging behaviour is provided.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------	-------------------------------------------------------------

The service provides an environment which minimises the risk of infection to residents, staff and visitors. Surveillance of infections is occurring according to the descriptions of the process in the infection prevention and control programme. Data on the nature and frequency of identified infections is collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance. Surveillance data is benchmarked against other Oceania facilities.

## 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	13	0	1	2	0	0
<b>Criteria</b>	0	38	0	1	2	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 service has systems in place to manage the complaints processes. The complaints process records a summary of the complaints, the investigation, outcome and other processes of complaints management. All complaints have resolution and documentation to support closure.</p> <p>Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. The complaint process was readily accessible and complaints forms are displayed for easy access. Residents and family interviewed confirmed having an understanding and awareness of these processes.</p> <p>Resident meetings are held bi-monthly and residents and their families are able to raise any issues they have during these meetings, as confirmed during interviews. Projects have been completed as a result of identifying shortfalls through complaints, adverse events monitoring and suggestions from residents.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and families. The residents' files reviewed provided evidence that communication with family members is documented in residents' records. There is evidence of communication with the general practitioner</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>(GP) and family following adverse events.</p> <p>The business and care manager advised access to interpreter services is available through the district health board, if required. Residents in the rest home and hospital as well as family members of residents in the dementia unit, confirmed that they are aware of the staff that are responsible for their care and staff communicate well with them. Admission agreements reviewed were signed and dated on admission.</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>The Oceania Care Company Limited's vision, values, mission statement and philosophy are displayed at the entrance to the facility, information in booklets and in staff training is provided annually.</p> <p>The organisation records their scope, direction and goals in their business, strategic and quality plans. The business and care manager provides monthly reports to the support office. Business status reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes and clinical indicators.</p> <p>The service has a business and care manager, supported by a clinical manager and the clinical quality manager. The clinical manager's position is full time, 40 hours per week. The clinical manager and the business and care manager have shared responsibility for all clinical matters. The business and care manager has a current annual practising certificate, has worked in aged care for 23 years and has been in this role for 12 years. The clinical manager's appointment was confirmed with HealthCERT, sighted a copy of the notification.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Eldon Rest Home uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to review and are current. All polices are reviewed by Support office, with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced based best practice guidelines. Policies are available to staff in hard copy. New and revised policies are presented to staff at staff meetings.</p> <p>A quality improvement plan with quality objectives was reviewed. These are used to guide the quality programme. Family/resident and staff satisfaction surveys are completed as part of their audit programme and collated results for surveys were reviewed. There is a hazard register that identifies health and safety risks, as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures. Service delivery is monitored through complaints, incidents and accidents, implementation of an internal audit programme, with corrective action plans documented and evidence of resolution of issues completed (refer 1.2.4.) There is documentation that includes collection, collation, and identification of trends and analysis of</p>

		<p>data.</p> <p>There are monthly staff/quality meetings, clinical meetings and health and safety meetings. Meeting minutes evidence communication with staff regarding all aspects of quality improvement and risk management. All meetings have an agenda and minutes are maintained with the identification of people responsible for outcomes and timeframes. Clinical indicators and quality improvement data are recorded and staff are informed at staff meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>The business and care manager is aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility, unexpected deaths, sentinel events, infectious disease outbreaks, and changes in key managers.</p> <p>Staff document adverse, unplanned or untoward events on an accident/incident form. This was confirmed in clinical records and during family/resident interviews. Incident and accident forms are reviewed and corrective actions are implemented by the clinical manager, however the records are not closed out by the business and care manager. Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Incident and accident records include pressure injuries. Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events. The service follows the Oceania policy regarding the management of incident and accidents.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Written policies and procedures in relation to human resource management are available and implemented. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checking, criminal vetting, completed orientation and induction records and competency assessments.</p> <p>An orientation/induction programme is available and new staff are required to begin this at the time of employment. The whole orientation process, including completion of competencies, takes up to three months. Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed an orientation; including competency assessments. Annual competencies are completed by care staff. The majority of staff in the dementia unit have completed appropriate training relating to the management of residents receiving dementia care and the rest of the staff members are in the process of completing this training.</p> <p>The clinical manager (CM), registered nurses (RN) and business and care manager (BCM) hold current annual practising certificates, along with other health practitioners involved in the service. The BCM is responsible for the in-service training programme. Clinical competencies were reviewed and current. All RNs are expected to</p>

		participate in the professional development review process (PDRP). An annual performance appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. There are 113 staff, including the management team, clinical staff, a diversional therapist, and household staff. Rosters were reviewed and there is enough staff cover to provide the services.</p> <p>Two registered nurses (RN) cover 24 hours a day. The CM on duty five days a week to support the RNs. The BCM and CM are on-call 24 hours a day, seven days a week. Health care assistants and family interviewed reported there are sufficient staff available.</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>	PA Moderate	<p>Medication areas in the hospital wings, including controlled drug storage, evidence an appropriate and secure medicine dispensing system. The rest home and dementia unit medication rooms require secure systems to be implemented. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded. Expired medicines are returned to pharmacy, however there were expired medicines sighted in the dementia unit.</p> <p>All staff authorised to administer medicines have current competencies. The medication rounds were observed and evidenced that the staff members were knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.</p> <p>Medicine charts evidence residents' photo identification, legibility, as required (PRN) medication is identified for individual residents and correctly prescribed, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. The rest home residents self-administering medicines, do so according to policy.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of</p>	FA	<p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known and accommodated in the daily meal plan. The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu. Special equipment, to meet resident's nutritional needs, was sighted.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal</p>

<p>service delivery.</p>		<p>complies with current legislation and guidelines.</p> <p>The effectiveness of chemical use, cleaning, and food safety practices in the kitchen are monitored. A cleaning schedule was sighted as is verification of compliance. Food temperatures are recorded as are fridge, chiller and freezer temperatures.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, sighted satisfaction surveys and resident meeting minutes, and meet the criterion identified as requiring improvement at last certification audit.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents, as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.</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 Moderate</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes, however not all wound care plans reflect current best practice.</p> <p>The residents' care plans evidence detailed interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records are current. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.</p> <p>Residents and family/whānau members expressed satisfaction with the care provided.</p> <p>There were sufficient supplies of equipment seen to be available that comply with best practice guidelines and meet the residents' needs.</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>FA</p>	<p>In interviews, the diversional therapists (DTs) confirmed the activities programmes meet the needs of the service group and the service has appropriate equipment. There is one activities programme for the rest home, one for the hospital residents and one programme for residents with dementia. Along with the activities staff, the health care assistants in the dementia unit implement individual residents' activities, as recorded on the residents' 24-hour activities care plans. Interviews with health care assistants confirmed this.</p> <p>Regular exercises and outings are provided for those residents able to partake. The activities programmes include input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations. There are current, individualised activities care plans in residents' files. The residents' activities attendance records are maintained. The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programme.</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>Time frames in relation to care planning evaluations are documented. The residents' care plans are up-to-date and reviewed six monthly. There is evidence of resident, family, health care assistants, activities staff and GP input in care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <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. Short term care plans are in some of the residents' files, used when required. The family are notified of any changes in resident's condition, confirmed at family interviews.</p> <p>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>	<p>FA</p>	<p>A current building warrant of fitness is displayed; the date of expiry is April 2017. There have been no building modifications since the last audit. The service has a scheduled maintenance plan which is implemented with an annual test and tag programme. This is up to date with checking and calibrating of clinical equipment, annually.</p> <p>Interviews with staff and observation of the facility confirm there is suitable equipment including; pressure relieving mattresses; shower chairs; hoists and sensor alarm mats.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet, providing privacy, when required. There are two courtyards and lawn areas with shade, seating and outdoor tables. The service has a secure unit for residents identified as requiring dementia care. Doors into the dementia unit have key pads to ensure that the service is a secure area.</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>The business and care manager (BCM) is the infection control nurse (ICN), who is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at facilities meetings.</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files evidenced the residents' who are diagnosed with infections have short term care plans.</p> <p>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.</p> <p>In interview, the ICN confirmed no outbreak occurred at the facility since last audit.</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>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 enabler use is recorded and implemented. There was one resident at the facility using an enabler and nine residents using restraint on the days of the audit. The restraint and enabler use are documented in residents' care plans.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.</p> <p>In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training is provided. The staff restraint competencies are current.</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 1.2.4.3</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>Incident and accident forms are completed. The family members are informed and corrective actions are identified and implemented. The clinical manager signs the forms in evidence of having implemented corrective actions. The forms provide opportunity for the business and care manager (BCM) to sign the incident/accident records when closing out the incident, however these records are not signed. Ten out of ten incident/accident records reviewed during the onsite audit were not signed by the BCM as closed out.</p>	<p>Incident and accident records are not closed out.</p>	<p>Ensure the BCM signs all incident/accident records in evidence of the incident having been closed out.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration,</p>	PA Moderate	<p>The medication rooms in the two hospital wings are secure and accessed by authorised persons only. Both hospital medication rooms have key pad access into the rooms. The rest home and the dementia unit medication rooms are accessed by a master key that all staff carry.</p> <p>In the dementia unit medication room there were expired medicines</p>	<p>i) The rest home and the dementia unit medication rooms can be accessed</p>	<p>Provide evidence:</p> <p>i) The medication rooms in the rest home and the</p>

<p>review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>sighted of residents' no longer residing in the unit. The expired medicines included Class C controlled drugs.</p>	<p>by unauthorised staff. ii) There are expired medicines in the dementia unit.</p>	<p>dementia unit are secure and only accessed by authorised staff. ii) The expired medicines are returned to pharmacy.  30 days</p>
<p>Criterion 1.3.6.1 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>The care plans reviewed evidence detailed interventions consistent with meeting residents' needs. The interventions/treatment plans for wounds do not reflect best practice.  The information relating to wound management at the facility, evidenced there were 48 wounds being treated at time of audit. Of the 48 wounds there were: 28 skin tears; 8 lesions; 6 open wounds; 3 PIs and 3 ulcers. Review of all wound management plans was conducted for the use of betadine. There were 18 wound management plans that included the use of betadine in the treatment of wounds. Discussions were held with the clinical manager and the business and care manager regarding the use of best practice around wound management.</p>	<p>The wound management plans do not reflect current accepted best practice.</p>	<p>Provide evidence the wound management plans reflect best practice.  30 days</p>

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

---

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

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

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

No data to display
--------------------

End of the report.