

Oceania Care Company Limited - Wesley Village

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:	Wesley Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 13 June 2016 End date: 14 June 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:	69

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

Wesley Rest Home (Oceania Care Company Limited) can provide care for up to 71 residents requiring care at either rest home, dementia or hospital level. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the district health board contract.

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

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.

Improvements required at the previous certification audit around labelling of chemicals and privacy for residents have been addressed.

Improvements are required to documentation of resolution of issues, documentation of discussion of clinical care and satisfaction survey results and security of chemicals.

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.

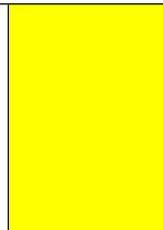


Standards applicable to this service fully attained.

Staff interviewed were 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 and complaints reviewed are investigated. Documentation is completed and stored in the complaints folder. Staff communicate with residents and family members following any incident, with this recorded in the resident 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.

Wesley Rest Home has documentation of the Oceania Care Company Limited 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.

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. The service has implemented an orientation and training programme for staff.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents receive services from suitably qualified and experienced staff. Care plan evaluations are documented, resident focused and indicate progress towards meeting residents' desired outcomes. Where progress of a resident is different from expected, the service responds by initiating changes to the long term care plan. Short term problems are recorded on short term care plans. Residents and their family have opportunity to contribute to care planning and reviews.

Recreational assessment and recreational plans are completed for residents. Activities are planned and there is evidence of input to the activities programme by an employed diversional therapist. The activities programme is available to residents throughout the service.

The medication management system evidences processes for reconciliation, prescribing, administration, dispensing, storage and disposal of medicines. Medicine management training is conducted. The service does not have any residents who self-administer medicines. All staff responsible for medicines management have current medication competencies.

Food and nutritional needs of residents are provided through the kitchen services by another facility close by and are in line with recognised nutritional guidelines. Menus are reviewed by a dietitian. Food service complies with current legislation and guidelines.

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.		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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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. The dementia unit is secure.

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 policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. There were five residents using restraint and one resident requiring an enabler on audit days. Staff education in restraint, de-escalation and challenging behaviour has been provided.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

Surveillance of infections is occurring according to the provider's policies. Policy suits their size and service type. Data on the nature and frequency of identified infections is collected, collated and analysed. The results of surveillance are reported through all levels of the organisation. The service reports infection surveillance data as part of key quality information to the governing body. The service participates in 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)
Standards	0	16	0	1	1	0	0
Criteria	0	40	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 are in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include periods for responding to a complaint. Complaint's 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. A complaint in 2016 was tracked and the review indicates that all timeframes taken to inform the family and resolve the issues raised were met.</p> <p>Residents and family members all stated that they would feel comfortable complaining.</p> <p>There have been complaints forwarded by external authorities in 2015 and all have been closed out.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in</p>	FA	<p>All windows in the facility either have curtains, blinds or frosted windows. There was no evidence that privacy for residents in their bedrooms was compromised in any way. Health care assistants and other clinical staff confirm that they keep privacy for residents by knocking on doors prior to entering, ensuring that curtains are shut when cares are being carried out and by shutting hallway doors that have frosted glass. The improvement required at the certification audit has been met.</p>

<p>a manner that has regard for their dignity, privacy, and independence.</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>If a 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 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 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 states that families are involved in resident care and can interpret, when required. There were residents requiring interpreting services at the time of the audit and staff described using cue cards, pictures and sign language. Family members interpret, when required, and staff who speak a resident's language converse with them as much as possible.</p> <p>All residents and family 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>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>Wesley Rest Home is part of the Oceania Care Company Limited, with the executive management team including the chief executive officer and organisational management team providing support to the service, as required.</p> <p>Oceania Care Company Limited has a clear mission, values and goals and staff interviewed are able to describe these. These are displayed in the service and residents and family interviewed are familiar with these.</p> <p>The facility can provide care for up to 71 residents requiring rest home, dementia or hospital level of care with 20 rooms identified in the secure dementia unit and 51 as dual-purpose. During the audit, there was occupancy of 69 residents (12 requiring rest home level care, 18 in the dementia unit and 39 requiring hospital level care). Five residents were under 65 years of age.</p>

		<p>The business and care manager has been in the management role in the service for five months with twenty years' experience in aged care management in other facilities. They are supported by the clinical manager who has been in the role for seven years. The business and care manager is a registered nurse and has over eight hours training per year in relevant topics.</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>	PA Low	<p>Wesley Rest Home uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice. The business plan is documented and reporting occurs through the business status reports. This includes: financial monitoring; review of staff costs; progress against the expected goals and review of other aspects of the business. The clinical indicator report is produced monthly and monitors clinical care with this provided to head office.</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. There is a document control programme in place. 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. The policy around pressure injuries has been reviewed and is ratified. Staff state they have read the policy with reference to this in the meeting minutes.</p> <p>Service delivery is monitored through complaints; review of incidents and accidents; surveillance of infections and implementation of an internal audit programme. There are monthly meetings with minutes documented that include the following: health and safety; staff/quality; registered nurse; infection control and resident and family meetings. Management meetings are held informally daily. All staff interviewed report that they are kept informed of quality improvements. Quality improvement data is discussed at meetings with some discussion of clinical data. Benchmarking and corrective action plans are documented with some evidence of resolution of issues. Improvements are required to these areas.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service, which include 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 a six monthly satisfaction survey for residents and family. The 2015 and 2016 surveys indicate that residents and family are satisfied with services provided. This was confirmed through interviews with family and residents on the days of audit. An improvement is required to ensure that results of the satisfaction survey are discussed at resident and family meetings.</p>
Standard 1.2.4: Adverse Event	FA	<p>The business and care manager and the clinical manager are aware of situations in which the service</p>

<p>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>		<p>would need to report and notify statutory authorities including police attending the facility; unexpected deaths; critical incidents; pressure injuries as per guidelines and infectious disease outbreaks. Times when authorities have had to be notified are documented and retained on the relevant file. This includes notification of any pressure injuries as per policy.</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 incident and accident reporting process. Staff interviewed understand the adverse event reporting process and their obligation to documenting all untoward events (refer 1.2.3.8).</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 Care Company Limited facilities (refer 1.2.3.6).</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. An annual appraisal process is in place with all staff files reviewed having a current performance appraisal on file. Criminal vetting is 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 stated that they have had an orientation that included reading of policies and procedures, introduction to residents, staff and to the service processes.</p> <p>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. Annual individualised training around core topics such as: medication; restraint; infection control; health and safety; manual handling and continence. Registered nurses have training through the district health board. This includes pain management; nutrition; assessments; medication administration and falls. Staff have completed training around pressure injuries in 2015, with a new training programme being held in 2016.</p> <p>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. Three registered nurses are interRAI trained, with one completing the course.</p>

		Of the eleven health care assistants who work in the dementia unit, six have completed training in dementia and three are enrolled. Two relieve only when necessary and do not have training around dementia. Education and training hours exceed eight hours a year for all staff reviewed. The health care assistants state that they value the training.
<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>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 indicate that residents requiring either hospital, dementia or rest home level of care are supported by an adequate number of staff on duty at any given time.</p> <p>There are two registered nurses (RNs) on duty at all times on the morning and afternoon shifts and two RNs on duty on four of the seven nights per week. The other three nights have one RN on duty to cover all areas.</p> <p>Residents and families interviewed confirm that staffing is adequate to meet the residents' needs.</p> <p>There were 56 staff at the time of the audit including: the business and care manager and the clinical manager. The cleaners and servery staff are appointed to cover seven days a week. There are activities staff who provide the activities programme five days a week and health care assistants who provide support to residents.</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>	FA	<p>The 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 evidences weekly checks and six monthly physical stocktakes. The medication fridge temperatures are completed and recorded.</p> <p>Current medication competencies for staff who administer medicines were sighted. Two medication round were observed and evidenced the staff members were knowledgeable about the medicines administered and signed off, as the dose was administered. Administration records and specimen signatures were maintained.</p> <p>Medication audits have been conducted and corrective actions are implemented following some of the audits (refer 1.2.3.8). There were no residents who self-administered medicines. Three monthly medicines reviews were conducted for the residents within the required timeframes.</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 service delivery.</p>	<p>FA</p>	<p>Interview with the servery manager confirmed kitchen staff have completed food safety training, this was verified by food safety certificates. The servery manager confirmed they were aware of the residents' individual dietary needs. Food for lunch and dinner mealtimes is prepared and provided by another nearby Oceania facility. The food is then transported in special food trolleys to Wesley Village. The servery manager monitors food temperatures on arrival and prior to the food being served. Breakfast is provided by the facility, prepared in their kitchen.</p> <p>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 April 2016. 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. The service had enough stock to last for three days, in an emergency situation.</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>FA</p>	<p>The residents' person's centred care plans (PCCP) evidence the required interventions, desired outcomes or goals of the residents. The GP documentation and records are current. In interviews, residents and family confirm 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. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.</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>The service employs a diversional therapist (DT) and an activities coordinator responsible for residents' activities. In interview with the DT, they confirmed the activities programmes are available to all residents in the rest home, the hospital, and the activities programme for residents with dementia, is displayed in the dementia unit, sighted a copy of the different programmes. The activities programmes includes input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations. Each resident in the dementia unit have a 24-hour activities plan on how to manage challenging behaviour.</p> <p>There are activities assessments and activities care plans in the residents' files reviewed. Activities care plans had intervention relating to the activities goals. The residents' activities attendance records are maintained as are activities progress notes.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Time frames in relation to care planning evaluations are documented. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews. 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 were sighted where required, in the residents' files. Family members are notified of any changes in resident's condition, confirmed at family interviews and in communication records. 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 October 2016). There have been no building modifications since the last audit.</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 equipment available. A test and tag programme is in place. Equipment is calibrated on an annual basis.</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 with indoor and outdoor areas that encourage residents to engage in activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	PA Moderate	<p>Cleaning is undertaken by staff who work seven days a week, with cleaners responsible for keeping chemicals secure when they are not present. All chemical bottles are labelled. The improvement required at the certification audit has been met. Some cupboards with chemicals in them were not secure and an improvement is required.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	<p>Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators on the Oceania intranet. 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</p>

<p>carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>infection control (IC) and health and safety meetings.</p> <p>The clinical manager (CM), who previously worked as an infection control nurse specialist (ICNS) in another service, is overseeing the surveillance programme during the absence of the infection control coordinator (ICC), who was on annual leave. The ICC completed additional training for the role as the ICC.</p> <p>The type of surveillance undertaken was appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events. Infection summary logs are maintained for infection events in individual resident's files reviewed. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers and progress notes.</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 clinical manager is the restraint coordinator and has a signed job description for the position.</p> <p>Interviews with staff members, observations, and review of documentation, demonstrated safe use of restraint and enablers. The service has a documented system in place for restraint and enabler use, including a current restraint register. There were five restraints and one enabler being used in the facility on audit days.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Meetings are held for staff, residents and family as per the schedule. There is evidence of some discussion of clinical data documented in meeting minutes. There are also informal discussions around clinical aspects of care and handover at the end of each shift.</p> <p>Satisfaction surveys are carried out on a six monthly basis. There are reports for the survey carried out in October 2015 and for the one circulated in March 2016. Results are expected to be discussed at the resident and family meetings, however this has not occurred to date.</p>	<p>While some clinical data is discussed, there is insufficient evidence in meeting minutes, particularly the registered nurse meetings, that clinical information is analysed and evaluated with improvements made as a result of the discussion.</p> <p>Results of satisfaction surveys are not discussed at the resident and family meetings to date.</p>	<p>Analyse and discuss clinical data with evidence that this is used to improve service delivery, including clinical care.</p> <p>Ensure that residents and family are informed of results of the satisfaction surveys and have the</p>

				opportunity to discuss the results. 90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective actions are documented as a result of issues raised in audits, discussion at meetings and through other quality improvement data. There is some indication that actions are signed off indicating resolution through meeting minutes, internal audits and most incident forms. The clinical manager and business and care manager state that the actions identified have been resolved, however, sign off is not documented.</p>	<p>Not all corrective actions have evidence of resolution of issues. This includes evidence of some actions still not resolved, as per timeframes, in meeting minutes, internal audits and in three of the twenty incident forms reviewed.</p>	<p>Ensure that issues are resolved as per timeframes documented in corrective action plans.</p> <p>90 days</p>
<p>Criterion 1.4.6.3</p> <p>Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	PA Moderate	<p>Some cupboards with chemicals in them were locked on the first day of audit, however, two (one in the dementia unit and one in the hospital/rest home area) were closed but not locked. Cleaners were observed to keep cleaning trolleys with them on the days of audit. The cupboard in the hospital/rest home area was locked on the second day of the audit however the cupboard in the dementia unit still had one bottle of chemicals in it and was unlocked.</p>	<p>A cupboard in the dementia unit was unlocked on two occasions and one cupboard with chemicals in the hospital/rest home was unlocked on the first day of audit.</p>	<p>Ensure that chemicals are always kept in a locked area when there is no staff member present</p> <p>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.