# Oceania Care Company Limited - Addington Lifestyle Care

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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: 1 February 2016 End date: 2 February 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:** 97

# 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 |
|  | 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

Addington Lifestyle Care (Oceania) can provide care for up to 97 residents requiring care at either rest home, dementia or hospital level with full occupancy 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.

Three improvements required at the previous audit have been addressed around management of complaints, corrective action planning and short term care planning. Improvements continue to be required to end of life directives and general practitioner review of medicines.

This surveillance audit identified improvements required to the following: resident feedback, the laundry service, smoking areas, further issues related to medication management and surveillance of infections.

## Consumer rights

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

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.

The previous improvement required around responding to complainants in a timely manner has been addressed.

There is an improvement required to end of life directives.

## Organisational management

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| 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. |

Addington Lifestyle Care 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. The previous improvement required around documentation of corrective action plans with these resolved in a timely manner has been addressed.

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.

An improvement is required to ensuring that resident feedback is managed.

## Continuum of service delivery

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| 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. |

There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into assessment, care planning, review of care and access to a typical range of life experiences and choices.

Residents’ long term care plans record detailed interventions and these are reviewed six monthly. Where resident’s progress is different from expected, the service responds by initiating changes to the long term care plan or recording the changes on a short term care plan.

Planned activities are appropriate to the group setting. 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.

Medication areas, including controlled drug storage evidence appropriate and secure medicine storage. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. Residents self-administering medicines do so according to policy. There are requirements for improvement relating to three monthly reviews and expiry dates of medicines.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. The kitchen staff have completed food safety training. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.

## Safe and appropriate environment

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| --- | --- | --- |
| 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 low risk. |

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 unit for residents requiring dementia level care with an indoor and outside area for residents.

Improvements are required to the laundry process to ensure there is a defined and used clean and dirty area and to smoking areas.

## Restraint minimisation and safe practice

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| 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. Residents using restraint and enablers do so according to the standard.

## Infection prevention and control

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

The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided. Surveillance of infections occur, however there is a requirement for improvement relating to surveillance records. The results of surveillance are reported through all levels of the organisation, including governance. Staff are familiar with infection control measures at the facility.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 12 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 3 | 2 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Moderate | There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.  All resident files identified that informed consent is collected. Interviews with staff confirmed their understanding of informed consent processes.  The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discusses informed consent processes with residents and their families during the admission process.  The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files noted that not all files had appropriately signed resuscitation directives and the previous improvement required at certification audit remains. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | 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’s forms are available in the facility.  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 complaint’s folder. Two complaints were tracked and the review indicates that all timeframes taken to inform the family and resolve the issues raised were met. The improvement required at the certification audit to responding to the complainant in a timely manner as per policy has been met.  Residents and family members state that they could complain, although there are issues related to follow up of the feedback (refer 1.2.3).  There have not been any complaints forwarded by the Health and Disability Commission, HealthCERT, district health board or other external authorities since the previous audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | 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.  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 in the residents’ files.  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.  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 are 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. Family in the dementia unit state that there are managers and registered nurses with whom they can raise any concerns.  An information pack is available in large print and staff interviewed advised that this could be read to residents. Family state that they read information and communicate this to residents in the dementia unit as much as possible. Information around the dementia unit is contained in the information pack given to residents and family on admission.  Staff training records includes training around communication. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Addington Lifestyle Care is part of the Oceania Care Company Limited with the executive management team including the chief executive officer and general manager, regional operational manager and clinical and quality manager who provide support to the service. Communication between the clinical and quality manager, the regional operations manager and the business and care manager takes place on a regular basis (at least once a month) with more support provided as required.  Oceania has a clear mission, values and goals and staff interviewed are able to describe these. These are displayed in the service.  The facility can provide care for up to 97 residents requiring rest home, dementia or hospital level of care. During the audit, there was an occupancy of 97 residents (27 requiring rest home level care, 28 requiring dementia level care and 42 requiring hospital level care). Four residents are under the age of over 65 years and there is one resident identified under the medical component of the provider’s certification identified as less than 65 years with a contract for a serious medical illness (SMI).  The business and care manager has been with the service for three years and has over ten years’ experience in management roles and over twenty years’ experience in aged care. The clinical manager provides clinical oversight of the service and has been in the role for six months. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Addington Lifestyle Care 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. 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.  The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required, with all policies current. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff and new and revised policies are signed by staff to say that they have read and understand them. The policy around pressure injuries has been reviewed and is in draft.  There are monthly meetings with minutes documented that include the following: management; health and safety; staff/quality; registered nurse and enrolled nurse and activities. All staff interviewed report that they are kept informed of quality improvements. There is evidence of documentation of corrective action plans and resolution of issues when these are raised through staff meetings or through the internal quality programme. The name and designation of the person/s responsible for the corrective action plan/s is documented along with timeframes for the corrective action. The previous improvements required around corrective action planning are now met. There are internal audits around pressure injuries with any issues discussed at relevant meetings.  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.  There are two monthly resident and family meetings and satisfaction surveys at least annually. An improvement is required to management of family and resident feedback.  The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service, which includes 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.  The previous audit identified improvements required around:  i) evidence corrective action plans are being developed, implemented, monitored and signed off as having been completed.  (ii) evidence the name/designation of the person/s responsible for the corrective action plan/s is documented along with timeframes for the corrective action. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | The business and care manager and clinical manager are aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks. Times when authorities have had to be notified are documented and retained on the relevant file. This includes notification of any pressure injuries to relevant authorities and completion of an incident form if a pressure injury is identified.  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.  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. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | 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, dietician, 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.  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. Three new staff interviewed state 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.  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. Staff have had two training sessions around pressure injuries in 2016.  All nine registered nurses and the clinical manager have completed training around interRAI assessments.  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. Education and training hours exceed eight hours a year for all staff reviewed. The health care assistants (HCA) state that they value the training.  All HCAs who work in the dementia unit have completed training in dementia. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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 dementia, hospital or rest home level of care are supported by an adequate number of staff on duty at any given time.  There is a registered nurse on duty at all times, based in the hospital, with oversight of all other areas, a registered nurse on weekdays on the morning shift in the rest home and an enrolled nurse or registered nurse on in the morning on weekdays in the dementia unit.  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.  There are 84 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, kitchen staff and laundry staff. There is a diversional therapist who provides oversight of the activities programme including the activities programme in the dementia unit. Specific staff who have completed training around dementia care are rostered in the dementia unit. Staff are replaced when on leave. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication areas, including controlled drug storage, evidence appropriate and secure medicine management systems, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug registers are maintained and evidence weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded.  Staff, authorised to administer medicines, have current competencies. Registered nurses, enrolled nurses and health care assistants (HCAs) interviewed were able to describe their roles regarding medicine administration. The medication rounds observed evidenced 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.  All medicines charts to be reviewed by the GP at three monthly intervals, expired medicines to be returned to the pharmacy and dates of when medicines are first opened, to be recorded. There was one resident who self-administered medicines in the rest home. The resident was appropriately assessed as being competent to self-administer medications and had safe storage for the medicines.  The previous requirement for improvement relating to three-monthly GP reviews of medicines charts remains open while the requirements regarding expiry dates of medicines are new requirements for improvement. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service policies and procedures are appropriate to the service setting with seasonal menus reviewed by the dietitian. A dietary assessment is undertaken for each resident on admission to the facility. A resident’s dietary profile is developed on admission and reviewed six monthly or when a resident’s condition changes. There are current residents’ dietary profiles in residents’ files and copies in the kitchen. The kitchen staff are informed if resident's dietary requirements change. Interviews with kitchen staff confirm their awareness of the residents’ dietary requirements. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Residents who require special eating aids are provided for to promote independence. The residents' files demonstrate monthly monitoring of individual resident's weight. Supplements are provided to residents with identified weight loss.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The residents' person centred care plans (PCCPs) evidence interventions based on assessed needs and desired outcomes or goals of the residents. In interviews, residents and their family confirm 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 confirm they are familiar with the current interventions of the resident they care for and that they have all the equipment referred to in care plans; necessary to provide care.  When a resident's condition changes, the registered nurse initiates a review and, if required, a GP consultation or referral to the appropriate health professional is actioned. Dressing supplies and continence products are available and treatment rooms are stocked for use. Short term care plans are recorded. Interventions for the short term problems are document to manage short term problems. |
| Standard 1.3.7: Planned Activities  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. | FA | Interviews with the diversional therapist (DT) and the activities coordinator confirm activities are provided throughout the week. The activities staff are responsible for planning, implementing and evaluating the activities programme. The activities programme records activities relating to residents’ preferences, ordinary patterns of life, group activities, exercises, outings and community activities. The activities programme is displayed around the facility and each resident has access to their own programme.  Residents are assessed for appropriate recreational activity and social requirements. There are activity assessments and current, individualised activity care plans in residents’ files. The residents’ activity attendance records are maintained. The residents’ meeting minutes evidence residents’ involvement and participation in planned activity programmes. Residents’ and family interviews confirm satisfaction with the activity programmes. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Time frames in relation to care planning evaluations are documented. Residents' care plans are 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 confirm 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 are used when required. Families are notified of changes in the resident's condition, as confirmed at family interviews. There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, when required.  The previous requirement for improvement relating to short term care plans to be in place is fully implemented. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date May 2016). There have been no building modifications since the last audit.  A planned maintenance schedule is implemented and the maintenance staff and documentation confirmed the implementation of this.  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.  Staff confirm that that there is sufficient equipment for staff to provide care and support to residents. A test and tag programme is in place. Equipment is calibrated.  There are safe external areas for residents and family to meet/use and these include paths, seating and shade.  There is a designated secure unit for residents assessed as requiring this. Residents have access to two internal secure outdoor areas with paths, shade and gardens.  There are a number of residents and staff who smoke and designated smoking areas. An improvement is required to smoking areas.  There is a designated small laundry and an improvement is required to use of clean and dirty areas. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Low | 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.  Residents with infections have short-term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on, monthly, at staff, quality, and infection control and health and safety meetings. Interviews confirmed information relating to infections is made available for clinical staff during hand over and at staff meetings.  The infection control coordinator is responsible for the surveillance programme. Monthly surveillance analysis is reported at facility’s meetings and to Oceania support office, however the surveillance outcomes after antibiotic use are not documented and closing dates for infections are not recorded.  Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. In interviews, staff report they are made aware of any infections of individual residents by way of feedback from 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. |
| 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 enabler use is documented in policies and procedures. 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.  In interviews with staff and in staff files there is evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training is provided. |

# 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.

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.7  Advance directives that are made available to service providers are acted on where valid. | PA Moderate | Five of ten files reviewed included advance directives that are signed by the resident deemed competent by the general practitioner. Other files included resuscitation directives signed by other family members or enduring power of attorney. | Five of ten files reviewed include resuscitation directive, as part of the end of life instructions, signed by the enduring power of attorney or family. The previous requirement identified at certification remains and the risk rating remains as moderate. The timeframe for the corrective action remains the same as at the certification audit. | Ensure that any resuscitation directive is signed by the resident who is deemed competent to sign the form.  30 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | There are two monthly resident and family meetings. Family and residents interviewed state that they can raise issues, but at times there is no feedback or resolution of issues. Family and residents are reluctant to talk to management about their ideas and issues, however there is a satisfaction survey completed at least annually that identifies issues. The business and care manager states that ideas and issues from the satisfaction survey are tabled at the resident meetings, however there is little evidence of corrective action plans documented with resolution of the issues. | Residents and family do not always wish to give feedback to managers.  Residents and family state that at times they do not see evidence of their feedback being actioned.  There is little evidence to indicate that there are corrective actions tabled when residents give feedback with evidence of resolution documented, for example: through the resident meetings and satisfaction surveys. | Provide an environment that is conducive to residents and family members being able to give feedback.  Provide ongoing feedback that enable family and residents to hear and see evidence of resolution of their issues.  Ensure that corrective action plans are documented when residents raise issues with evidence of resolution of issues.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The service has policies and procedures for safe and appropriate medicines management. | i) Three of twenty medicines charts reviewed were not reviewed by the GP within three months  ii) Medicines in the medicines room were expired and not within the safety timeframes anymore  iii) eye drops and nasal sprays did not have the date on which they were opened recorded on the containers. | i) All medicines charts to be reviewed at three monthly intervals  ii) expired medicines to be returned to the pharmacy  iii) all eye drops and nasal sprays to have the date when opened recorded on the container.  30 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | There are a number of residents and staff who smoke and designated smoking areas.  There is a designated small laundry with identified clean and dirty areas. | Smoke drifts into resident areas as observed on a number of occasions during the audit. One tin of cigarette butts was overflowing on the days of the audit.  Staff on the days of the audit folded clean linen in the dirty area. | Ensure that resident areas are smoke free and that smoking areas are kept clean.  Ensure that staff use designated clean areas for clean linen.  30 days |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | PA Low | Surveillance processes are in place and the service completes surveillance at monthly intervals. | 1) Surveillance outcomes after the use of antibiotics are not recorded  ii) and closing dates recording the solutions of infections are not recorded. | i) Surveillance outcomes to be recorded for all infections and  ii) the closing dates and or when a problem is on-going to be recorded as part of the surveillance process.  90 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.