

Oceania Care Company Limited - Te Mana Home & Hospital

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Oceania Care Company Limited

Premises audited:

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

Dates of audit: Start date: 17 December 2015 End date: 18 December 2015

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: 43

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

General overview of the audit

Te Mana Home and Hospital can provide care for up to 46 residents requiring care at either rest home or hospital level, including young people with disabilities. On the days of audit the service had 13 young people with occupancy of 43 residents in total. 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 nurse leader and the support office team.

All improvements required at the last certification audit requiring corrective action plans being documented and medicines administration sheets to be signed were implemented. This surveillance audit identified improvements required to service provision requirements, evaluation of services, medicines management and planned activities.

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. | | Standards applicable to this service fully attained. |
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Staff interviewed are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and care for the residents. Information regarding the complaints process is available to residents and their family and complaints reviewed are investigated with documentation completed and stored in the complaints folder. Staff communicate with residents and family members following any incident.

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. | | Standards applicable to this service fully attained. |
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Te Mana Home and Hospital has implemented the Oceania quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and business status reports allow for the monitoring of service delivery. Benchmarking reports include clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented. Corrective action plans are documented with evidence of resolution of issues when these are identified. Staffing levels are adequate across the service with human resource policies implemented.

Continuum of service delivery

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| <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> |
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The resident's initial care plan is utilised as a care guide for staff, while the long term care plan is developed over the first three weeks of admission. Risk assessments are completed and care plans are evaluated. The care plan evaluations do not consistently record the degree of response to interventions and this requires an improvement. Short term care plans are used for short term problems. Relatives are notified regarding changes in a resident's condition. Areas requiring improvement relate to completion of the interRAI assessments and recording of GPs exceptions to indicate a resident's condition is stable and medical reviews are only required three monthly.

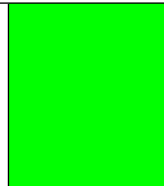
There is an activities programme provided at the facility. There are areas requiring improvement around the activities care plans and the activities programme for the residents under 65 years of age. The residents and families interviewed expressed satisfaction with the activities provided at the facility.

Medicine management policies and procedures are documented. Staff medication competencies are current for all staff that administer medications. A previous area requiring improvement relating to staff signing all administered medications has been met. New areas requiring improvement following this surveillance audit relate to dating of residents' photos and verification that medicines are checked upon arrival to the facility.

Food, fluid and nutritional needs of residents are provided in line with nutritional guidelines and are appropriate to the age group. The menus have been reviewed by the dietitian.

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.

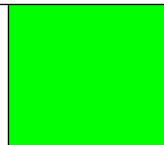


Standards applicable to this service fully attained.

There is a current building warrant of fitness. A planned and reactive maintenance programme is in place, with issues addressed as they arise. Residents and family interviewed describe the environment as meeting their needs, with indoor and outdoor areas that have seating and shade.

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.

Policies and procedures comply with the standard for restraint minimisation and safe practice. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There was one resident using an enabler and eight residents using restraints on audit days. Staff education in restraint, de-escalation and challenging behaviour had 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.

The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided. Infections are investigated and collected monthly for benchmarking. Appropriate interventions are in place to address infections.

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 | 12 | 0 | 2 | 2 | 0 | 0 |
| Criteria | 0 | 37 | 0 | 2 | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>FA</p> | <p>The organisation's complaints policy and procedures are in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include timeframes for responding to a complaint. Complaint forms are available in the facility and family and residents interviewed know where they can get a form from.</p> <p>Two of the 2015 complaints reviewed indicate that the complaints are investigated promptly with the issues resolved in a timely manner. There is documented evidence of periods being met for responding to these complaints with complainants happy with the outcome in each case. Documentation for each complaint on file indicates that each complaint is thoroughly investigated with letters on file to confirm that complainants have been informed of receipt of the complaint and the outcome with any staff involved documenting actions taken. Documentation includes staff signatures, names and designations.</p> <p>The complaints register in place includes: the date the complaint was received; the source of the complaint; a description of the complaint and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaints folder. The complaint that was made to the DHB was reviewed and evidence</p> |

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| | | showed that the complaint was investigated and resolved. |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <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. Family are informed if the resident has an incident, accident, a change in health or a change in needs as confirmed in a review of accident/incident forms and in the resident files. Family contact is recorded in residents' files. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member and can attend the resident meetings.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. All are signed on the day of admission</p> <p>Interpreting services are available when required from the district health board. The business and care manager stated that families are involved in resident care and can interpret when required. At the time of the audit, there was one resident requiring interpreting services for specific tasks and there were two staff members who were able to interpret on a daily basis for them. All residents interviewed confirm that staff are approachable and communicate well with them. An information pack is available in large print and staff interviewed advised that this could be read to residents. Staff training records include annual training around connecting with people and communication.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>Te Mana Home and Hospital is part of the Oceania Care Company Limited with the executive management team, including the chief executive officer, general manager, the national operations manager, regional operational manager and regional clinical and quality manager, providing support to the service.</p> <p>Communication between the regional clinical and quality manager, the regional operations manager and the business and care manager takes place on a regular basis (at least once a month), with more support provided, as required. The monthly business status report provides the executive management with progress against identified indicators.</p> <p>There is a clear mission statement, values and goals. These are communicated to residents; staff and family through posters on the wall, information regarding the services are in booklets and in staff training, provided annually.</p> |

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| | | <p>Oceania has a clear mission, values and goals and staff interviewed were able to describe these. These were observed to be displayed in the foyer of the service.</p> <p>The facility can provide care for up to 46 residents requiring rest home or hospital level of care. The facility is contracted to provide services to young people with disabilities (YPD). During the audit there were 43 residents at the facility including five residents requiring rest home level of care and 38 requiring hospital level care. These numbers include 13 residents identifying as young people with disabilities.</p> <p>The business and care manager is responsible for the overall management of the facility and has been in the role for 18 months. The business and care manager has been in management of primary general practice and aged care services. The business and care manager is supported by a clinical nurse leader, who is also a registered nurse and has been in the role for five years.</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>Te Mana Home and Hospital 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.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required, with all policies current. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff and new and revised policies are signed by staff to say that they have read and understand them.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. Quality improvement data is analysed and corrective action plans are documented with evidence of resolution of issues. The previous requirement related to documentation of resolution of issues has been addressed. There are monthly meetings with minutes documented that include the following: management; health and safety; restraint and quality/staff. Clinical (registered nurse) meetings are held four weekly with resident and family meetings held bi-monthly. Staff report that they are kept informed of quality improvements.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management</p> |

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| | | programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly. There is an annual satisfaction survey for residents and family. The survey completed in 2015 indicates that residents and family are satisfied with care and support provided. The recommendations identified as a result of the survey have been completed with improvements implemented. |
| <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> | FA | <p>The business and care manager and clinical nurse leader are aware of situations that the service would need to report on 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.</p> <p>Staff records reviewed demonstrates 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. The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes.</p> <p>Incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>Human resource policy and processes are in place. All registered nurses hold current annual practising certificates along with other health practitioners involved with the service. Current visiting practitioners' practising certificates reviewed are current and include the general practitioners, pharmacists, dietitian, podiatrist and physiotherapist. Staff files include employment documentation such as job descriptions, contracts and appointment documentation on file. Police and drug checks are completed and an annual appraisal process is in place with all applicable staff having a current performance appraisal.</p> <p>All staff have completed a comprehensive orientation programme. Preceptors are appointed and there is a longer time given for new staff to complete orientation when applicable. Staff files show completion of orientation. Staff are able to articulate the buddy system in place and the competency sign off process completed.</p> |

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| | | <p>Mandatory training is identified on an Oceania wide training schedule. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training held. The service has a varied approach to ensuring that staff receive annual training that includes attendance at training sessions and annual individualised training around core topics such as: medication; restraint; infection control; health and safety; manual handling and continence. The training register and training attendance sheets show staff completion of annual medication and other competencies such as: hoist; oxygen use; hand washing; wound management; moving and handling; restraint; nebuliser; blood sugar and insulin.</p> <p>Staff attendances are documented. Education and training hours is at least eight hours a year for each staff member.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | 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 were checked to ensure that residents requiring either hospital or rest home level of care were well supported according to individual need. Evidence reviewed and observations confirmed that residents requiring hospital level of care were well supported with a registered nurse on duty at all times. Residents requiring rest home level of care are encouraged to be as independent as possible and there is a registered nurse on duty for rest home residents in the morning.</p> <p>Residents and families interviewed confirm that staffing is adequate to meet the residents' needs.</p> |
| <p>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 Low | <p>Medication areas, including controlled drug storage evidences 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 stock takes. The medication fridge temperatures are conducted and recorded.</p> <p>All RNs authorised to administer medicines have current competencies. RNs are knowledgeable about the medicine administered and sign off, as the dose is administered. This was an area requiring improvement at the last certification audit and has been met. Administration records are maintained, as are specimen</p> |

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| | | <p>signatures. Staff education in medicine management is conducted.</p> <p>Medicines charts record all medications the resident is taking, including name, dose, frequency and route to be given. All medicine entries on the medicines charts are signed and dated by the GP. Allergies are recorded. The residents' photos are not dated and do not consistently evidence the current resemblance of the residents. Discontinued medicines are signed and dated. Three monthly GP reviews are signed off in the medicines charts. Medications are checked by the RN upon arrival to the facility, however no records of this have been kept.</p> <p>Self-administration of medicine policies and procedures are in place and the residents who self-administer their medicines do so according to the policies and procedures.</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> | FA | <p>The food service policies and procedures are appropriate to the service setting with a seasonal menu reviewed by a dietitian.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile is developed and reviewed regularly. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight, and this is conducted more frequently when this is required. In interviews, residents stated they are satisfied with the food service, reported their individual preferences are met and adequate food and fluids are provided.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Daily records of fridge, freezer and chiller temperatures are recorded. Food temperatures are monitored and records maintained. Kitchen staff have food safety training. There are sufficient staff on duty in the dining room at meal times to ensure appropriate assistance is available to residents as needed.</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> | FA | <p>Individualised interventions are documented for each goal as identified in the long term care plans reviewed. Documentation and observations made of the provision of services and/or interventions demonstrated that consultation and liaison is occurring with other services. Referrals to other agencies were sighted in residents' files reviewed. The GP documentation and records are current.</p> <p>Visual inspection evidenced that there were adequate continence and dressing</p> |

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| | | <p>supplies.</p> <p>Residents and family involvement in the development of care plans and review of the care plans is encouraged. Multidisciplinary meetings are recorded and conducted with the resident and/or family.</p> <p>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 confirm 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> | PA Low | <p>The activities coordinators (ACs) plan, develop, implement and review the activities programme. There is one activities programme for the facility. The activities programme addresses the abilities and needs of the residents in the hospital and the rest home. However the programme does not record the specific activities for the residents under 65 (YPD). Activities attendance records are maintained and resource materials are accessible for the staff to utilise.</p> <p>On admission the AC or the RN completes a recreation assessment for each resident. The RNs complete the activities section of the long term care plan for all residents. Individual activities care plans are completed for residents under 65 by the ACs, however these do not consistently align with the long term care plans. Evaluation of the long term care plans, including the activity section of the care plan are completed every six months. All resident files reviewed during the onsite audit had current activity assessments in place.</p> <p>Residents and family confirmed they are satisfied with the activities programme.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | PA Moderate | <p>The residents' files reviewed evidenced the long term care plans are reviewed six monthly. Evaluations are documented, however they do not consistently indicate the degree of response to interventions and the progress towards meeting the resident's goals.</p> <p>Clinical reviews are documented in the multi-disciplinary review records, and include all staff involved in the care of the resident. The progress notes are completed by the health care assistants and RNs. Short term care plans are developed for acute problems and include goals and interventions. The short term care plans are evaluated daily by the RNs.</p> <p>The residents' progress records are entered on each shift and reflect response to</p> |

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| | | <p>interventions and treatments. When resident's progress is different than expected, the RN contacts the GP, as required. The family are notified of any changes in resident's condition, confirmed at family interviews.</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> | FA | <p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 4 June 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. The following equipment is available: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There is an annual test and tag programme and this is up to date with the checking and calibrating of clinical equipment annually. Equipment relevant to care needs is available and staff confirm that this is always sufficient. The lounge areas are designed so that space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids. There are safe external areas for residents and family to meet/use and these include paths, seating and shade.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>The clinical leader is the infection control coordinator (ICC) and is responsible for the surveillance programme for this service. 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 control information is collated on a monthly basis and documented in the infection logs. Infections are investigated and appropriate plans of action are recorded and implemented. Short term care plans are completed for infections and kept with the surveillance logs and residents' files.</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>The organisation has a benchmarking system in place and this is shared with all Oceania facilities. The surveillance results are discussed at facility's meetings and also communicated to staff via graphs relating to infection rates and benchmarking across the organisation.</p> |

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| <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. The restraint and enabler registers reflect restraints and enabler use in the service. There was one resident using an enabler and eight residents using restraint at the facility on audit days. 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 and evidenced in the resident's files.</p> <p>The role of the restraint coordinator is the responsibility of the clinical leader. Restraint meetings were sighted for July, September and November 2015.</p> <p>In interviews with staff and in staff records there is 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> |
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|--|-------------------|---|---|---|
| <p>Criterion 1.3.12.1</p> <p>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.</p> | PA Low | <p>The previous area requiring improvement from the last certification audit relating to staff signing all administered medications has been met.</p> <p>All medication charts reviewed evidenced the residents' photos did not have dates recorded on the photos. In the medication file, there is a separate front sheet with the resident's photo and the resident's photo is also on the medication chart. There was evidence these two photos were not consistently the same photos of the resident, hence the resident's resemblance differed. On second day of the audit the RNs commenced dating the residents'</p> | <p>i) Resident's photos in the medications file are not dated to ensure the residents' current appearance.</p> <p>ii) There are no records to verify that medicines are checked upon arrival to the facility.</p> | <p>i) Provide evidence the residents' photos are current</p> <p>ii) Ensure there is recorded evidence that the medication is checked upon arrival to the facility.</p> <p>90 days</p> |

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| | | <p>photos in the medication file.</p> <p>An interview with the clinical leader confirmed the medications are checked upon arrival to the facility, however there are no records to verify this. On the second day of the audit a record was completed of the checking of the last intake of medications from the pharmacy.</p> | | |
| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | <p>PA</p> <p>Moderate</p> | <p>The residents' are medically reviewed by the GP every three months or when acute problems arise. The residents' files sampled do not record GP exceptions to indicate the residents' are stable and able to be medically reviewed every three months.</p> <p>There are risk assessments completed on resident's admission to the facility, these are reviewed six monthly or when resident's needs change. RNs are trained in the use of the interRAI assessment tools. The residents' admitted after 1 July 2015 do not have interRAI assessment completed or in progress. An interview with the clinical leader confirmed the interRAI assessment completed externally by the referring agency is reviewed on admission, however new interRAI assessment is not completed within 21 days of admission to the facility.</p> | <p>i) GP exceptions are not recorded to indicate that residents' are medically stable and able to be reviewed three monthly, instead of monthly.</p> <p>ii) The interRAI assessments are not completed within the required timeframe.</p> | <p>i) Provide evidence the GP exceptions are recorded to indicate that residents are medically stable and able to be medically reviewed three monthly.</p> <p>ii) Provide evidence the interRAI assessments are completed within the required timeframe.</p> <p>90 days</p> |

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| <p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | <p>PA Low</p> | <p>There is one activities programme which is displayed weekly and provided to those residents' that request the programme.</p> <p>All residents (rest home, hospital and young person with disabilities (YPD)) have a recorded activities care plans as part of the long term care plan, which are reviewed six monthly. The YPD residents have additional weekly social and recreational care plans, which are completed by the ACs and held in a folder in the activities room. These social and recreational plans record specific activities goals of the YPD resident, however they do not record interventions and do not evidence evaluations have been completed. The tracer methodology of the hospital YPD evidenced the social and recreational care plan and the interest and activities recorded on the long term care plan do not align.</p> <p>The activities that are specific to the YPD residents are not recorded on the activities programme for the facility.</p> | <p>i) There are two activities plans for the YPD residents (social and recreational plan and a section of the long term care plan). The YPD social and recreational plan, completed by the ACs, does not include interventions or evaluations. The social and recreational care plan and the section on the long term care plan relating to interest and activities do not align. The YPD social and recreational plans are not integrated into residents' files.</p> <p>ii) The activities programme does not record the specific activities for the YPD residents.</p> | <p>i) Provide evidence the social and recreational care plan for the YPD residents include interventions and evaluations and are integrated into the resident's file.</p> <p>ii) Provide evidence the activities programme records specific activities for the YPD residents.</p> <p>180 days</p> |
| <p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress</p> | <p>PA Moderate</p> | <p>Care plan evaluations are completed according to the specified timeframes or when the resident's condition changes. The documented evaluations did not consistently record the degree of achievement</p> | <p>The care plan evaluations do not consistently record the degree of achievement to the support towards meeting resident's outcomes.</p> | <p>Provide evidence all care plan evaluations record the degree of achievement towards meeting the resident's desired outcomes.</p> |

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| towards meeting the desired outcome. | | towards meeting the resident's desired outcomes. | | 90 days |
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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.

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End of the report.