

Oceania Care Company Limited - Eden Lifestyle Care & 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:

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

Dates of audit: Start date: 21 January 2016 End date: 21 January 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: 68

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
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

Eden Lifestyle Care and Village (Oceania) can provide care for up to 70 residents requiring care at either rest home or hospital level with 68 residents on the day of audit. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the district health board contract.

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

The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager, regional and executive management team. Service delivery is monitored.

This surveillance audit identified improvements required to the following: the quality and risk management programme, training, wound management, assessments and administration of medication.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff interviewed are able to demonstrate an understanding of residents' rights and obligations including the complaints process. Information regarding the complaints process is available to residents and their family and 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 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 medium or high risk and/or unattained and of low risk.
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Eden Lifestyle Care and Village has documentation of the Oceania quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and business status reports allow for the monitoring of service delivery. Benchmarking reports include clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented. Corrective action plans are documented with evidence at times of resolution of issues when these are identified.

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

Improvements are required to analysis of quality data, documentation of resolution of issues and to training for staff around pressure injuries.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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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. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices.

A sampling of residents' clinical files validated the service delivery to the residents. Assessments and care plans are completed within the required timeframes, with the exception of the interRAI assessments. Long term care plans are evaluated six monthly. Where progress is different from expected, this is recorded on a short term care plan. Short term care plans are not consistently being evaluated. Some aspects of the wound management system are identified as areas requiring improvement.

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.

There is an appropriate medicine management system in place. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. The residents self-administering medicines do so according to policy. There are areas identified as requiring improvement around discontinued medication, photo identification and medication fridge temperatures.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Residents have a role in food choices. There is a central kitchen and on site staff that provide the food service. The kitchen staff have completed food safety training.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family interviewed describe the environment as appropriate with indoor and outdoor areas that meet their needs.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation policy and procedures 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. There were six residents using restraint and no residents requiring enablers on audit day.

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.
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Surveillance of infections is occurring according to the descriptions of the process in the infection control programme. 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.

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	11	0	0	5	0	0
Criteria	0	35	0	1	5	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 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.</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 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.</p> <p>Residents and family members all state that they would feel comfortable complaining.</p> <p>There has been one complaint forwarded by the Health and Disability Commission since the previous audit lodged in 2015. The Health and Disability Commissioner's office has responded with a request for further information (HDC) and the complaint continues to be addressed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</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.</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>If the resident has an incident, accident, a change in health or a change in needs, then family are informed, as confirmed in a review of accident/incident forms and in the resident 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 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. The business and care manager has an open door policy that allows residents, family and staff to communicate any issues at any time.</p> <p>An information pack is available in large print and staff interviewed advised that this could be read to residents.</p> <p>Staff training records includes training around connecting with people and communication.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Eden Lifestyle Care and Village 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 providing support to the service on the day of the audit. Communication between the clinical and quality manager, the regional operations manager and the business and care manager takes place on a regular basis (at least once a month) with more support provided as required.</p> <p>Oceania has a clear mission, values and goals and staff interviewed are able to describe these. These are displayed in the service.</p> <p>The facility can provide care for up to 70 residents requiring rest home or hospital level of care (all dual-purpose beds). During the audit, the occupancy was 68; (33 residents requiring rest home level care and 35 requiring hospital level care). All residents at the time of the audit were over 65 years.</p> <p>The business and care manager has been with the service for three months having had management experience at another Oceania facility for over eight years. The business and care manager is a registered nurse and is a member of the ADHB steering committee for falls and pressure injuries. The clinical manager provides clinical oversight of the service.</p>
<p>Standard 1.2.3: Quality And</p>	<p>PA</p>	<p>Eden 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</p>

<p>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>Moderate</p>	<p>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 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. This has been sent to business and care managers to make final comment.</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 can be analysed through meetings and benchmarking and corrective action plans are documented. Improvements are required to analysis and discussion of data and documentation of evidence of resolution of issues.</p> <p>There are monthly meetings with minutes documented that include the following: management, health and safety; staff/quality, registered nurse, activities and care suite resident and family meetings. There are weekly maintenance meetings and health care assistant meetings two monthly or as required. All staff interviewed 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 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.</p> <p>There is a six monthly satisfaction survey for residents and family. The end of year survey completed in 2015 indicates that residents and family is currently being collated however the previous satisfaction survey indicated that residents were satisfied with the service overall.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau</p>	<p>FA</p>	<p>The business and care manager and clinical manager are aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, 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 the acting clinical manager to HealthCERT.</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</p>

<p>of choice in an open manner.</p>		<p>event reporting process and their obligation to documenting all untoward events.</p> <p>Incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities.</p>
<p>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>PA Moderate</p>	<p>Human resource policy and processes are in place. All registered nurses hold current annual practising certificates. Current visiting practitioners' practising certificates reviewed are current and include the general practitioners, pharmacists, dietitian, podiatrist and physiotherapist. Staff files include employment documentation such as job descriptions, contracts and appointment documentation on file. Criminal vetting is completed and an annual appraisal process is in place with all staff files reviewed having a current performance appraisal on file. A spreadsheet is kept of the dates of performance appraisals completed.</p> <p>A comprehensive orientation programme is available for staff. Staff files show completion of orientation. Staff are able to articulate the buddy system in place and the competency sign off process completed. 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.</p> <p>Mandatory training is identified on a training schedule. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training held. Staff receive annual training that includes attendance at training sessions and annual individualised training around core topics such as medication, restraint, infection control, health and safety, manual handling and continence. Registered nurses have an hour of training at each meeting that includes relevant topics such as pain management, complaints management, nutrition, assessments, medication administration and falls. An improvement is required to training around pressure injuries.</p> <p>There are two registered nurse trained to complete InterRAI assessments and another recently employed (due to start on the 25 January 2016) who is also trained. Two registered nurses are enrolled in the training.</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. Education and training hours exceed eight hours a year for all staff reviewed. The health care assistants state that they value the training.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy. Rosters indicate that residents requiring either hospital or rest home level of care are supported by an adequate number of staff on duty at any given time.</p> <p>There is a registered nurse on duty at all times.</p> <p>Residents and families interviewed confirm that staffing is adequate to meet the residents' needs during the weekdays. The same staffing model is applied in weekends.</p> <p>There are 62 staff at the time of the audit including the business and care manager, the clinical manager (acting). Household staff are appointed and include cleaners who provide seven day a week cleaning, kitchen staff including two chefs and a baker along with a kitchen manager. There are two activities staff providing activities five days a week.</p> <p>The building is on two levels and staff are allocated to work in each level. There is an equal mix of rest home and hospital level of care on both levels and staff are given an equal mix of rest home and hospital residents to care for. Staff also work in pairs and as a team to ensure that hospital residents are given appropriate care and support relative to their needs. There are always two staff for example, when using a hoist as described by staff interviewed and as observed on the day of audit.</p> <p>The facility is part of a retirement village however staff are not responsible to providing care to people in the village.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Medication areas, including controlled drug storage areas evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted, however temperatures are not within recommended temperature range.</p> <p>All staff authorised to administer medicines have current competencies. The medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.</p> <p>Medicine charts evidence legibility, as required (PRN) medication is identified for individual residents and correctly prescribed and three monthly medicine reviews are conducted. Residents' photo identification is not always dated and discontinued medicines are not consistently dated and/ or signed by the GPs. The residents' medicine charts record all medications a resident is taking (including name, dose, frequency</p>

		and route to be given). The residents self-administering medicines do so according to policy.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service policies and procedures are appropriate to the service setting with a seasonal menu reviewed by a dietitian.</p> <p>In interview, the chef confirmed they are aware of the residents' individual dietary needs. The residents' dietary requirements are identified, documented and reviewed on a regular basis. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the chef.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided.</p> <p>The food temperatures are recorded, as are the fridge, chiller and freezer temperatures. All decanted food is dated. Kitchen staff completed food safety training.</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>The residents' care plans evidence detailed interventions based on assessed needs, desired outcomes or goals of the residents, however the wound care plans do not consistently meet best practice guidelines (refer to criterion 1.3.3.3).</p> <p>The GP documentation and records are current. In interviews, residents and family confirmed that current care and treatments meet their and their relatives' 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>	FA	<p>In interview, the activities coordinator (AC) confirmed the activities programme meets the needs of the service group and the service has appropriate equipment. There is one activities programme for the rest home and hospital residents.</p> <p>Regular exercises and outings are provided for those residents able to partake. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. There are current, individualised activities care plans in residents' files and these are reviewed at the same time the long term care plans are reviewed. The residents' activities attendance records are maintained. The residents' meetings are conducted two to three monthly and include residents' involvement and consultation of the planned activities programme.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Time frames in relation to care planning evaluations are documented. The residents' long term care plans are up-to-date and reviewed six monthly. There is evidence of resident, family, health care assistants, activities staff and GP input in care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <p>The residents' progress records are entered on each shift. When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans are in some of the residents' files, used when required. The short term care plans include short term goals and detailed intervention, however they are not being consistently evaluated when required and wound care plans evaluations are not being completed when required. The family are notified of any changes in resident's condition, confirmed at family interviews.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date August 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 this is sufficient. A test and tag programme is in place. Equipment is calibrated.</p> <p>There are safe external areas for residents and family to meet/use, and these include paths, seating and shade.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organisation. Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators on the intranet.</p> <p>Residents with infections have short-term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on a monthly basis at staff, quality, and infection control and health and safety meetings. Interviews confirmed information relating to infections is made available for clinical staff during hand over and at staff meetings.</p> <p>The infection control coordinator (ICC) is responsible for the surveillance programme. Monthly surveillance</p>

		<p>analysis is completed and reported at staff meetings (refer to criterion 1.2.3.6).</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short term care plan (refer to criterion 1.3.8.2).</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interview, the ICC confirmed no outbreak had occurred at the facility since last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There were no residents at the facility using enablers and six residents using restraint. Review of residents' files using restraint evidenced the required processes are followed and recorded in the files.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.</p> <p>In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training was provided.</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>	<p>PA Moderate</p>	<p>There is an established meeting schedule and data is tabled at the meetings. There is evidence in meeting minutes of discussion around some aspects of the data with some evidence of improvements made because of the discussions. This includes discussion of pressure injuries, incidents and wounds particularly at registered nurse and quality/staff meetings. The clinical manager and staff interviewed are able to describe how data would lead to improvements.</p>	<p>At times, data is tabled and there is little evidence of analysis and discussion around the data that would lead to service improvements.</p>	<p>Ensure that data is analysed and discussed with evidence of quality improvement as a result.</p> <p>90 days</p>
<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</p>	<p>PA Low</p>	<p>There is a process to record resolution of issues as these are identified. There is sign off of resolution of issues on most occasions and this includes documentation in internal audits, which is documented well.</p>	<p>Evidence of resolution of issues is not always completed and this includes documentation in health and safety meeting minutes for</p>	<p>Ensure that evidence of resolution of issues is recorded as this occurs.</p> <p>90 days</p>

implemented.			example.	
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>Seventeen of the thirty-seven care staff have completed training around pressure injuries in 2015 and an improvement is required.</p>	<p>Insufficient staff have completed training around management and monitoring of pressure injuries in 2015 and registered nurses were not familiar with definitions and descriptions of pressure injuries.</p>	<p>Ensure that staff receive training around pressure injuries.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The temperatures of the medication fridges evidence they are not within the required temperature range. Review of maintenance records did not evidence this had been reported and no follow-up corrective action could be identified. Staff interviewed were aware of the required protocol.</p> <p>Medication files evidenced the discontinued medications were not consistently being dated and /or signed by the GP. Four of the nineteen medication charts reviewed evidenced this.</p> <p>One of the nineteen medication files does not have a resident's photo in place. The remaining eighteen medication charts evidenced six photos were not dated and did not indicate residents' true likeness.</p>	<p>i) Residents medication files evidenced the discontinued medicines are not consistently signed and /or dated by the GP.</p> <p>ii) Residents photos do not consistently record the date the photo was taken and true likeness of the resident.</p> <p>iii) Medication fridge temperatures are outside of the recommended temperature range</p>	<p>i) Provide evidence the discontinued medications are signed and dated by the GP</p> <p>ii) Provide evidence residents' photos on the medication charts are dated and confirm true likeness of the resident</p> <p>iii) Provide evidence the medication fridge temperatures are within recommended temperature range.</p>

				90 days
<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 Moderate</p>	<p>Of the four wound care plans reviewed, there was one wound care plan that had the frequency of dressing changes recorded. Interview with the RNs confirmed wounds are usually attended to in two to three day intervals, however this is not consistently recorded. The wound plans for the resident with pressure injuries do not adhere to best practice guidelines. Interview with the clinical manager confirmed the new wound regime was commenced without any input from wound care nurse specialist or research indicating this is best practice. GP has been notified of the wounds.</p> <p>Review of the residents' files evidenced the interRAI assessments are not consistently being completed within the required timeframes. RN's interviewed stated they are trained in interRAI.</p>	<p>i) Wound management plans do not consistently record the frequency of dressings required.</p> <p>ii) InterRAI assessments are not consistently completed when required</p> <p>iii) Wound management plans do not consistently evidence best practice guidelines</p>	<p>i) Provide evidence the wound management plan record the required frequency of dressing changes.</p> <p>ii) Provide evidence the interRAI assessments are completed within 21 days after admission and every six months thereafter or when required due to a significant change in resident's condition.</p> <p>iii) Provide evidence wound management adheres to best practice guidelines.</p> <p>90 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</p>	<p>PA Moderate</p>	<p>Long term care plans are evaluated six monthly. Six short term care plans were reviewed of which five were found not to have been evaluated. Five wound care plans were reviewed and all five wound care plans did not evidence completed evaluations.</p>	<p>Short term care plans and wound care plans do not record evidence of evaluations being consistently</p>	<p>Provide evidence the short term care plans and wound care plans are evaluated.</p>

intervention, and progress towards meeting the desired outcome.			completed.	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.

No data to display

End of the report.