

# Oceania Care Company Limited - Whitianga Continuing 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](#).

The specifics of this audit included:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Whitianga Continuing Care
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 8 August 2017 End date: 9 August 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	46

# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Whitianga Continuing Care provides rest home and hospital level of care for up to 54 residents. There were 46 residents residing at the facility on audit days. There have been no changes to the organisation since the last audit.

This surveillance audit was conducted against the relevant Health and Disability Service Standards and the service contract with the district health board. The audit process included the review of policies, procedures, resident and staff files, and observations and interviews with residents, family, management, staff and a general practitioner.

The previous requirements for improvement have been met. There is one area requiring improvement from this audit relating to adverse events.

## 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.
--	--	--

Information regarding residents' rights, access to advocacy services and how to lodge a complaint is available to residents and their families.

Residents are informed and have choices related to the care they receive. There is a documented and implemented complaints management process that complies with the Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. A complaints register is maintained and complaints/concerns are viewed as an opportunity for improvement.

## 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.
---	--	--

Oceania Healthcare Limited has a documented quality and risk management system that supports the provision of clinical care at Whitianga Continuing Care. The quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status reports. Policies and procedures are reviewed at Oceania Healthcare Limited support office and these are current.

Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators. These are used to provide comparisons with other Oceania Healthcare Limited residential care facilities and inform staff.

There are human resource policies implemented around: recruitment; selection; orientation; staff training and development and support employment practice.

The 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. Staff are allocated to support residents' individual needs.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--	--	--

The processes for planning, provision of care, evaluation and review of care and exit from the service are provided and within the timeframes that safely meet the needs of the resident and meet contractual requirements.

The service is coordinated in a manner that promotes a team approach to care delivery. The person-centred care plans for both rest home and hospital level residents, describe the needs and the interventions required. Where progress is different than normal, the service responds by initiating changes to the care plan or with the use of short-term care plans. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided was of a high standard.

Registered nurses are on duty 24 hours each day in the facility and supported by care and allied health staff, including a podiatrist, pharmacist and a contracted physiotherapist as required. On-call arrangements for support are in place. Shift handovers and communication sheets guide continuity of care.

The service provides a recreational programme including group and individual activities and maintains the residents' links with the community. A facility van is available for outings. The activities are both planned and spontaneous ensuring that the skills and interest of the residents are maintained.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using an electronic system. Medications are administered by registered nurses. Ongoing education and medication competencies are completed annually.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was observed to be clean and meets food safety standards. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

The facility has a current building warrant of fitness. There have been no alterations to the building since the last audit.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

Restraint minimisation and safe practice policies and procedures reflect current good practice and meet legislative and Health and Disability Services Standard requirements. Enablers are described as voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the annual education plan to maintain restraint use. Staff interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes. At the time of audit there was one restraint in use and no enablers.

## Infection prevention and control

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

Surveillance for infections is undertaken monthly. Results of surveillance are analysed to assist in achieving infection reduction. The infection surveillance results are appropriately reported to staff and management in a timely manner.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	1	0	0
Criteria	0	39	0	0	1	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisation's complaints policy and procedure is in line with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Consumer's Rights (the Code) and includes periods for responding to a complaint. The complaint forms are available at the entrance to the facility.</p> <p>A complaints register is in place and 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. One complaint had been received in 2017 and this was reviewed. On review of the complaint, evidence demonstrated it was investigated promptly with the issues resolved in a timely manner.</p> <p>Residents and family members interviewed stated they would feel comfortable complaining.</p> <p>The business and care manager confirmed there had been no complaints with the Health and Disability Commission since the previous audit or with other authorities.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>Policies and procedures, such as accidents/incidents, complaints and open disclosure, guide staff on the process of open disclosure of information. Management and staff notify family/enduring power of attorney of accidents/incidents that occur or when a resident's condition alters. Family contact is recorded in the residents' clinical files. Interviews with family members confirmed they are kept informed. Family members also confirmed</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>they receive newsletters from the facility and are invited to attend resident meetings.</p> <p>Interpreter services are available from the district health board. There were no residents requiring interpreting services on audit days.</p> <p>The facility information pack is provided to residents and family and contains all required information regarding the services provided at the facility. Residents or family sign an admission agreement on entry to the service.</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>Whitianga Continuing Care is part of the Oceania Healthcare Limited (Oceania). The business and care manager (BCM) is responsible for the overall management of the facility. The BCM has been in the role for two years. The clinical manager (CM) is a registered nurse (RN) who has been in this position since 2005. Both managers undertake education and training relevant to their roles, exceeding eight hours annually. The BCM is supported in the role by the Oceania support office staff. The Oceania clinical and quality manager provided support during the on-site audit. Communication between the business and care manager and the Oceania clinical and quality manager takes place on a monthly basis or more frequently as required.</p> <p>Oceania has a clear mission, values and goals and these are communicated to residents, staff and family.</p> <p>The facility can provide care for up to 54 residents. There are 53 dual purpose rooms, with 20 hospital level residents and 26 rest home level residents at the time of the audit. One room is allocated to rest home level of care only. The additional services provided at the facility are long-term residential services contract for people under 65 years with chronic health conditions (no residents at time of audit) and residential respite services contract (three residents under this contract, one hospital and two rest home level of care). Other contracts are the transitional care contract with no residents at the time of audit and primary care inpatient services contract with one resident at hospital level of care.</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</p>	<p>FA</p>	<p>Whitianga Continuing Care uses the Oceania quality and risk management framework that is documented to guide practice. The BCM reports to the Oceania support office monthly through the business status reports. There is a documented operational and business plan for the facility.</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. The policies are linked to the Health and Disability Service Standards, current and applicable legislation, and evidenced-based best practice guidelines. The policies are readily available to staff in hard copy. New and revised policies are communicated to staff to ensure staff are kept informed.</p> <p>The service delivery is monitored through: complaints; review of incidents and accidents; surveillance of infections; pressure injuries; soft tissue/wounds; and implementation of an internal audit programme. The quality</p>

improvement principles.		<p>data evidences: collection; collation; identification of trends: analysis and documentation and implementation of corrective actions where this is required. The quality data reports are communicated to Oceania support office. Benchmarking reports are produced by the Oceania support office and provide comparisons with other Oceania residential care facilities. This data is shared with all Oceania facilities, staff and management.</p> <p>Facility's meetings and meeting minutes provide evidence of communication with management and staff around all aspects of quality improvement and risk management. Interviews with staff confirmed they are informed about quality activities. There are planned resident and family meetings that keep residents informed of any changes and provide opportunity for discussions. There is a six monthly family and resident satisfaction survey with a high level of satisfaction documented at the last survey conducted.</p> <p>The Oceania health and safety annual plan records a list of tasks to be implemented and there is evidence this is being implemented. The progress of this plan is reviewed by the BCM and at the health and safety monthly meetings. Health and safety objectives are recorded and signed off by the BCM. Risk registers are documented and reviewed.</p> <p>The area identified as requiring improvement at the last certification audit relating to resolving issues following facility meetings has been met.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Moderate	<p>The management team are aware of the situations and events in which the service would need to report and notify statutory authorities. There were no times since the last audit when authorities have had to be notified. There was one sentinel event notified to the Oceania support office and this has been investigated and closed out.</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 receive education on the incident and accident reporting process at orientation and as part of the ongoing mandatory training programme. The staff interviews confirmed their understanding of the adverse event reporting process. However, the accident/incident reports reviewed did not consistently have a corresponding note in the residents' progress notes to inform staff of the incident. The neurological recordings were not consistently completed for unwitnessed falls. There was evidence of open disclosure for each recorded event.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>The RNs and the CM have current annual practising certificates, along with other health practitioners involved with the service.</p> <p>The staff files reviewed included all required employment documentation, including, but not limited to, appointment documentation; signed contracts; job descriptions; reference checks and interviews. There is a staff</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>appraisal process in place and this is up to date.</p> <p>There are documented orientation programmes for specific staff roles within the organisation which include the essential components of the service provided. All staff complete an orientation programme and this was evidenced in staff files reviewed. The health care assistants (HCA) are paired with a senior HCA for shifts or until they demonstrate competency on a number of tasks including personal cares. The staff interviewed confirmed the review of the orientation programme with a new staff member stating that this process is followed.</p> <p>The organisation has a mandatory education and training programme that is required for staff under the Age-Related Residential Care Service Agreement and the Health and Disability Service Standards. The staff attendances are documented with all staff undergoing this mandatory training. The education and training hours were at least eight hours a year for each staff member. Staff interviews confirmed the mandatory study days are informative and valuable. External providers are also included when providing staff education and training. The interRAI training and competency has been achieved by a total of five staff (three RNs and two enrolled nurses).</p> <p>Clinical competencies are completed by care staff and include: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; restraint; nebuliser; blood sugar and insulin; and assisting residents to activities of daily living.</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 and skill mix policy is documented and implemented. The interview with the BCM confirmed the 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.</p> <p>At the time of the audit, there were 60 staff including 10 RNs, 2 enrolled nurses, 3 activities coordinators, 26 HCAs and kitchen, housekeeping and maintenance staff. The rosters sighted evidenced there is one RN and one enrolled nurse rostered on each morning from Monday to Sunday with four HCAs. Management confirmed additional staff are rostered if resident numbers or acuity increases. On afternoon shifts and night duty there is one RN rostered with four HCAs. The night shift comprises of one RN and two HCAs. The BCM and CM are on call and staff are aware of this.</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</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Twelve RNs and two senior healthcare assistants have completed competencies for</p>

<p>and safe practice guidelines.</p>		<p>medication management and the training records were reviewed.</p> <p>Medications are supplied to the facility in a pre-packed format from a contracted pharmacy. These medications are checked by the receiving RN against the prescriptions. All medication sighted were within current use by dates. Clinical pharmacist input is provided six monthly and audits are undertaken.</p> <p>Drugs are stored securely in accordance with requirements. Drugs, where appropriate are checked by two RNs for accuracy in administration. The drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine refrigerator was within the recommended range.</p> <p>Prescribing in line with best practice was noted, including the management for pro re nata (PRN) medicines. The required three-monthly general practitioner (GP) reviews are consistently recorded on the medicine record electronically.</p> <p>There are two rest home level residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the CM and/or the RN and recorded on an incident form. The resident and/or the designated representative is advised. There is a process for comprehensive analysis of any medication errors, and compliance with this was verified. Medication errors have decreased significantly with the electronic medication system in place.</p> <p>Standing orders are used, are current and comply with guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a head cook, second cook and kitchen team and is in line with recognised nutritional guidelines for older people. The cook interviewed discussed the menu planning process. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Any recommendations at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan. The food safety plan certificate is displayed in the dining room. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the food plan. The head cook and staff interviewed have all undertaken a safe food handling qualification and completed all relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is readily available.</p>

		Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms in all service areas at meal times, to ensure appropriate assistance is available to residents as needed.
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The general practitioner interviewed verified that medical input is sought in a timely manner, that medical orders are followed and care is managed effectively and in a caring manner by all staff. Healthcare assistants confirmed that care is provided as outlined in the documentation. A range of equipment and resources were readily available, suited to the level of care provided in each care setting, being rest home and hospital care, and in accordance with the residents' needs.
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	<p>The activities programme is provided by three staff, two activities coordinators and one healthcare assistant who works the weekend as the activities coordinator.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities/recreational assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six-monthly or more often if required as part of the formal PCCP review.</p> <p>The planned monthly activities programme sighted and displayed matches the skills, likes, dislikes and interests identified in assessment data reviewed. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group and regular events are offered. Examples include exercise to music, involvement in the community, networking with other rest homes, entertainment, theme days and special events, music, bingo, card games and pet therapy. Van outings occur weekly into the community.</p> <p>The activities calendar is discussed at the minuted residents' two monthly meetings and indicated residents' input is sought and responded to. The minutes are displayed on the notice board near the recreation room. Resident and family satisfaction surveys demonstrated satisfaction with the activities provided and that information gained is used to improve the range of activities offered. Residents interviewed confirmed they find the programme interesting and fun in which to participate.</p> <p>For those residents who are unable to participate in group activities, one on one activities are provided as reflected in the activities calendar. The three activities coordinators contribute to the Whitianga Cares newsletter.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is also reported to the RN and/or the clinical leader.</p> <p>Formal PCCP evaluations occur every six months in conjunction with the six monthly interRAI reassessments or a resident's needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for recurrent falls, weight loss and progress evaluated as clinically indicated daily, weekly or fortnightly and according to the degree of risk noted during the assessment process. Other plans such as wound and pressure injury management plans were evaluated each time the dressing was checked/changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>The building warrant of fitness is current. There have been no alterations to the facility since the last audit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Criterion 1.4.6.3 was identified as requiring improvement at the last certification audit relating to safety of chemicals and labelling of chemical containers. Visual inspection of the facility evidenced safe storage of chemicals with all chemical containers labelled appropriately. This evidence confirmed the criterion is fully met. An external company provides chemical supplies for the facility. Material data sheets as well as regular monitoring is conducted by the contracted supplier.</p>
<p>Standard 3.5: Surveillance</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long-term aged care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. When an infection is identified, a record of this is documented on the infection reporting form. The infection control coordinator, an experienced RN, reviews all</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>reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of surveillance are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year and comparisons against previous years. This is reported to the Oceania clinical and quality manager and the business and care manager. Data is benchmarked externally with the organisation's other aged care providers. Benchmarking has provided reassurance that infection rates in the facility are below average for the sector.</p> <p>Any new infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the RNs and general staff meetings, as confirmed in the meeting minutes sighted and interviews with staff.</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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the CM who is responsible for oversight for enabler and restraint management in the facility. The restraint coordinator demonstrated a sound knowledge of the organisation's policies, procedures and practice and their role.</p> <p>On the day of the audit one resident was using a restraint and no residents were using enablers. Enablers, when in use, are the least restrictive and used voluntarily at a resident's request. This provides for a robust process which ensures the on-going safety and wellbeing of the resident.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and records reviewed of those residents who have approved restraints and from interview with staff.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA</p> <p>Moderate</p>	<p>The clinical files reviewed evidenced the accident/incident forms were completed and signed off by the BCM. The family members are notified when adverse events occur, this was confirmed by family interviews and the clinical file reviews. Fifteen adverse event forms and the process followed were reviewed. There was evidence three of the fifteen adverse event forms did not have a corresponding record of the event in the residents' progress notes. The residents' adverse events of unwitnessed falls did not evidence the neurological recordings were either conducted or, if commenced, did not continue for a period of time required. This was evidenced in nine of the nine unwitnessed fall events reviewed.</p>	<p>The adverse events are not consistently recorded in the progress notes and the neurological recordings were not always completed when required.</p>	<p>Provide evidence the adverse events are consistently recorded in the residents' progress notes and the neurological recordings are completed when required.</p> <p>90 days</p>

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

---

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

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

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

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

End of the report.