

# Oceania Care Company Limited - Wesley Village

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## Introduction

This report records the results of a Certification 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>	Wesley Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 17 October 2017      End date: 18 October 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>	58

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Wesley Village (Oceania Healthcare Limited) can provide care for up to 72 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. Occupancy on the day of the audit was 58. The service provides rest home, dementia and hospital level care.

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

The previous business and care manager resigned four weeks prior to the audit. Oceania Healthcare Limited's acting business and care manager is responsible for the overall management of the facility and is supported by the regional and executive management team. Service delivery is monitored. There are requirements for improvement relating to communication, complaints and the laundry service.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible in information packs and displayed within the service. Staff are respectful of residents' needs.

Residents, families and enduring power of attorney are provided with information required prior to giving informed consent. Support is provided if any discussions and explanation are required relating to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

A complaints register is maintained. Complaints are managed as per timeframes in the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. There is one coroner's enquiry that remains open.

## 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.		Standards applicable to this service fully attained.
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Oceania Healthcare Limited is the governing body and is responsible for the service provided at Wesley Village. The acting business and care manager is a registered nurse, holds a current practicing certificate and is qualified and experienced in management systems and processes. The clinical manager has been in the role for twelve months and is supported by the clinical

and quality manager (regional), the operations manager (regional) and the senior clinical and quality manager (national) regarding oversight of the service and clinical care.

Oceania Healthcare Limited has a documented quality and risk management system that supports the provision of clinical care at the service. Policies are reviewed at support office and are current. Quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status reports. Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators. Resident information is identifiable, accurately recorded, current, confidential, accessible when required and securely stored.

There are human resource policies implemented around recruitment, selection, orientation, staff training and development. Staff, residents and family confirmed that staffing levels are adequate. Staff are allocated to support residents as per their 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.
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The organisation works closely with the local Needs Assessment and Service Coordination Service, to ensure access to the facility is appropriate and efficiently managed.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff. The service has contracted a team of two general practitioners and one nurse practitioner to provide the medical care for the residents. On-call arrangements for support from senior staff are in place. Shift handovers and communication books guide continuity of care.

The person centred care plans are individualised and based on a comprehensive and integrated range of clinical information. Short-term care plans are developed to manage any new problems that might arise. All residents' records reviewed demonstrated

that needs, goals and outcomes are identified and reviewed on a regular basis. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers and a current interRAI assessment completed prior to transfer.

The planned activity programme, overseen by two activities coordinators, provides the residents with a variety of individual and group activities and maintains their link with the community. One activities coordinator organises the programme for the rest home and hospital level residents and the other for the secure dementia service.

Medicines are managed according to policies and procedures. Medications are administered by registered and senior care staff all of whom have been assessed as competent to do so.

The food service meets all food safety standards and the nutritional needs of the residents with special requirements catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. Food is prepared off-site and delivered to this site twice a day, seven days a week.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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All building and plant comply with legislation, with a current building warrant of fitness in place. The environment is appropriate to the needs of the residents. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents are provided with accessible and safe external areas. Residents' rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Essential emergency and security systems are in place and fire drills completed every six months. Call bells are available to all residents and are monitored monthly.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that supports the minimisation of restraint. Four enablers and seven restraints were in use at the time of the audit. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and thereafter every two years, including all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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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The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice is able to be accessed from the district health board, microbiologist, physician and the general practitioner. The programme is reviewed annually.

Staff demonstrated sound practice and understanding around infection control, which is guided by relevant policies and procedures and supported with regular education.

Aged care specific surveillance is undertaken, analysed, trended and benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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	47	0	3	0	0	0
Criteria	0	98	0	3	0	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Residents confirmed that they receive information and services that meet their needs. Staff receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme.</p> <p>All staff have had training in the Code during the previous 12 months and interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice including: maintaining residents' privacy; informed consent; giving residents choices; encouraging independence and ensuring residents can continue to practice their own personal values and beliefs. The auditors noted respectful attitudes towards residents on the days of the audit. Any challenging behaviours were managed for residents in the dementia unit in a respectful and supportive manner.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau</p>	FA	<p>There is an informed consent policy and procedure that guides staff in relation to gathering of informed consent. Resident files identified that informed consent is obtained. Interviews with staff confirmed their understanding of informed consent processes. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of</p>

<p>of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>that care.</p> <p>The service information pack includes information regarding informed consent. The ABCM and CM discuss informed consent processes with residents and their families during the admission process. The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files noted that all had appropriately signed advance directives. The general practitioner makes a clinical decision around resuscitation and ongoing treatment for residents who are not able to make an advance directive (and have no advance directive documented in the past). The advance directive is discussed with the family and/or EPOA prior to the doctor signing the form.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Resident information relating to advocacy services is available at the entrance to the facility and in information packs provided to residents and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Staff training regarding advocacy services was last provided in 2017 and is a component of the Oceania annual training programme.</p> <p>Family and residents confirmed that the service provides opportunities for the family/EPOA to be involved in decisions and stated that they have been informed about advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has an open visiting policy and residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can access after doors are locked by using the front door bell. Families confirmed they could visit at any time and are always made to feel welcome.</p> <p>Residents are encouraged to be involved in community activities and to maintain family and friend networks. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments.</p>
<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>PA Low</p>	<p>The organisation's complaints policy and procedures are in line with the Code and include timeframes for responding to a complaint. Complaint forms are available at the entrance of the facility. A complaints register is in place and includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved.</p> <p>Evidence relating to each lodged complaint is held in the complaints folder and documented on the register. Complaints reviewed indicated that 3 of the 17 complaints in 2017 did not have sufficient evidence of resolution and/or follow up with the complainant. Staff, residents and family confirmed they</p>

		<p>knew the complaints process.</p> <p>The ABCM is responsible for managing complaints. Three of the five families interviewed, had made complaints and had not received follow up or feedback. The families had subsequently lodged official complaints relating to the lack of feedback. Residents and family members could describe their rights and advocacy services particularly in relation to the complaints process.</p> <p>Since the last audit there was a Health and Disability Commissioner enquiry as a result of a complaint which has been closed. There is currently an open coroner's enquiry.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The acting business and care manager (ABCM) and the clinical manager (CM) discuss the Code with residents and their family on admission. Discussion relating to the Code is also included on the agenda and discussed at the residents' meetings.</p> <p>Resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. The posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Wesley Village has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Resident's support needs are assessed using a holistic approach. The initial and ongoing assessment gains details of people's beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner, with strategies documented to manage any inappropriate behaviour if there are any issues for a resident.</p> <p>The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility (both in the rest home and dementia unit) which can be used for private meetings.</p> <p>Healthcare assistants reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families confirmed that residents' privacy is respected.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of</p>

		<p>quality care. Staff receive annual training on abuse and neglect and can describe signs. Residents, staff, family and the general practitioner confirmed that there is no evidence of abuse or neglect.</p> <p>Resident files reviewed evidenced cultural and/or spiritual values and individual preferences are identified.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service implements the Māori health plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. The service continues to try to develop links to local kaumātua and Māori services but can also access support through the district health board. There are staff who identify as Māori and staff reported that specific cultural needs are identified in the residents' care plans. There are Māori residents currently using the service and they have a cultural assessment and plan in place.</p> <p>Staff are aware of the importance of whānau in the delivery of care for the Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies each resident's personal needs from the time of admission. This is achieved with the resident, family and/or their representative. There is a culture of choice with the resident determining when cares occur, times for meals and selection of meals and activities. Staff work to balance service delivery, duty of care and resident choice. Staff are also able to describe how residents in the dementia unit have choice, for example, around what clothes to wear and what food to choose.</p> <p>Residents and/or family are involved in the assessment and the care planning processes as sighted in files reviewed. Information gathered during assessment includes the resident's cultural values and beliefs. This information is used to develop a care plan.</p> <p>Staff are familiar with how translating and interpreting services can be accessed. The current multicultural staff mix are able to act as interpreters for the residents and families as required.</p> <p>There is a focus on ensuring that individual activities encourage independence.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility implements the Oceania Healthcare Limited (Oceania) policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care.</p> <p>Job descriptions include: responsibilities of the position; ethics; advocacy and legal issues. Job descriptions were sighted in staff files reviewed and were relevant to the role held by the staff member.</p>

		The orientation and employee agreement provided to staff on induction include standards of conduct. Interviews with staff confirm their understanding of professional boundaries, including the boundaries of the healthcare assistants' role and responsibilities.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Wesley Village implements Oceania policies to guide practice. These policies align with the health and disability services standards and are reviewed biannually. A quality framework supports an internal audit programme. Benchmarking occurs across all the Oceania facilities.</p> <p>There is a training programme for all staff and managers are encouraged to complete management training. There are monthly regional management meetings. Specialised training and related competencies are in place for the registered nursing staff. Review of staff files indicated training and competencies are completed annually by all staff, relevant to their role.</p> <p>Residents and families interviewed expressed satisfaction with the care delivered.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/EPOA of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Completed accident/incident forms evidenced family are informed if the resident has an incident/accident, has a change in health, or a change in needs.</p> <p>Family contact is recorded in residents' files, however, they are not consistently kept informed in relation to family concerns and expectations are not always addressed and/or communicated to staff. Family confirmed that they are invited to the care planning meetings for their family member and could 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>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Wesley Village is part of the Oceania Healthcare Limited (Oceania) with the executive management team providing support to the service. Communication between the service and managers occur monthly with the clinical and quality manager providing support during the audit. The monthly business status report provides the executive management with progress against identified indicators.</p> <p>The organisation's mission statement and philosophy are displayed at the entrance to the facility. Information in booklets is given to new residents and staff training is provided annually.</p>

		<p>The service has an acting business and care manager (ABCM) supported by a clinical manager (CM). The ABCM has been in the role for a week. The CM has been in the position for 12 months and is supported by the clinical and quality manager (CQM). The management team is well supported in their roles and have completed appropriate induction and orientation to their roles.</p> <p>The facility can provide care for up to 72 residents.</p> <p>On the first day of audit there were 58 residents living at the facility, including 11 residents requiring rest home level of care, 34 residents requiring hospital level of care, and 13 requiring dementia level care. Included in these numbers were 3 hospital level residents under 65 years under the young person's disability contract. The facility also holds a respite contract.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence of the ABCM, the CM is responsible for the day to day operation of the service and is supported by a senior registered nurse and the regional CQM and the regional operations manager. In the absence of the CM, the ABCM with the support and help of the regional CQM, ensures continuity of clinical services.</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>	FA	<p>Wesley Village uses the Oceania quality and risk management framework that is documented to guide practice.</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. Support office reviews all policies, with input from business and care managers. 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 in hard copy. New and revised policies are presented to staff and sign to confirm they have read and understood the new/revised policies.</p> <p>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, with corrective action plans documented. Documentation includes collection, collation and identification of trends and analysis of data.</p> <p>There are a range of meetings held to discuss data. These include: monthly staff/quality meetings, clinical meetings and health and safety meetings. Meeting minutes evidence communication with all staff</p>

		<p>around all aspects of quality improvement and risk management. There are also two monthly resident meetings that keep residents informed of any changes. Staff report that they are kept informed of quality improvements and can have input into discussions and review of service delivery.</p> <p>There is a six-monthly family and resident satisfaction survey with results collated and evidence of improvement implementation plans.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management 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.</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>	FA	<p>The ABCM is aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility, unexpected deaths, sentinel events, infectious disease outbreaks, and changes in key managers.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and could describe the importance of recording near misses.</p> <p>Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed, with evidence of improvements put in place.</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>The ABCM, CM and registered nurses hold current annual practising certificates along with other health practitioners involved with the service.</p> <p>Staff files included appointment documentation, for example, signed contracts, job descriptions, reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal.</p> <p>All staff complete an orientation programme and healthcare assistants (HCA) are paired with a senior HCA for shifts or until they demonstrate competency on a number of tasks, including personal cares. HCAs confirmed their role in supporting and buddying new staff.</p> <p>Annual competencies are completed by care staff, for example, hoist, oxygen use, hand washing, wound management, medication management, moving and handling, restraint, nebuliser, blood sugar and insulin, and assisting residents to shower. The organisation has a mandatory education and training programme. Staff attendances are documented. Education and training hours are at least eight hours a</p>

		<p>year for each staff member. Registered nurses training records indicated they had well in excess of eight hours training in the past year around clinical topics, for example, wound management, management of challenging behaviour and de-escalation and continence. Staff working in the dementia unit have completed training modules specific to dementia care. There are two interRAI trained registered nurses.</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 workforce 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. Staff confirmed that they have sufficient time to complete cares scheduled. There are 53 staff, including the management team, clinical staff, a diversional therapist, and household staff. There is always a registered nurse on each shift. The ABCM and CM are on call after hours. Residents and families confirmed staffing is adequate to meet the residents' needs. The service is undertaking as a review of the duty rosters and currently advertising for a business and care manager and healthcare assistants.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service holds relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information could be accessed in a timely manner.</p> <p>Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including designation.</p> <p>Resident files are protected from unauthorised access by being locked away in an office, either in the main home and dementia unit.</p> <p>Information containing sensitive resident information is not displayed in a way that it could be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder with medication. Staff interviewed stated that they read the long term plans at the beginning of each shift and are informed of any changes through the handover process.</p> <p>All components of the residents' records reviewed include the resident's unique identifier. The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Medication charts are kept separate from residents' files. Resident files and medication charts are accessed by authorised personnel only.</p>

		Residents' progress notes are completed on every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes identify the name and designation of the person making the entry.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or families are encouraged to visit the facility prior to admission and meet with the clinical manager and/or the facility administrator. They are provided with written information about the service and the admission process. The service operates a waiting list for entry when full. The organisation seeks updates information from NASC or the general practitioner (GP) for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Records reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and coordinated manner, with an escort as appropriate. The service uses the DHBs 'yellow envelope' system to facilitate transfer of residents to and from acute services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, is provided for the ongoing management of the resident. When a resident is transferred this is documented in the progress records. Family reported at interviews they are being kept well informed during the transfer of their relative to the DHB when required.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management. A safe system for medicine management was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medication sighted were within current use by dates. Clinical pharmacist input is provided and six-monthly audits are completed.</p> <p>The records of temperatures for the medication fridge are within the recommended range. The</p>

		<p>requirements for pro re nata (PRN) medicines is met. Should any resident in the dementia service require PRN medication, it is the responsibility of the registered nurse to administer this medication.</p> <p>There are two residents self-administering medications at the time of the audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Any medication errors are reported to the clinical manager and recorded on an incident form. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are used, are current and comply with guidelines. There is a copy the standing orders attached to the side of each of the three medication trollies.</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>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 and registration issued in June 2017. Food temperatures, including high risk items, are monitored appropriately and recorded as part of the plan. Food is prepared off-site at another Oceania facility. The food service manager interviewed by telephone has undertaken a safe food handling qualification with kitchen assistants at the main kitchen completing relevant food handling training as evidenced in training records.</p> <p>The meals are delivered by van twice a day before lunchtime and before the evening meal. A kitchen hand serves the meals on arrival to this facility. Care staff are responsible for assisting residents with their meals and for clearing the tables and washing the dishes after the two main meals. Breakfast is provided on-site by staff. The food is delivered on a trolley to the secure dementia service each mealtime. The staff serve the food for the residents from the kitchen which is in close proximity to the lounge and dining room in the dementia unit. Residents have access to food and fluids to meet their nutritional needs at all times.</p> <p>The menu used follows summer and winter patterns and has been reviewed by a dietitian within the last two years.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to the chef at the main kitchen and to the kitchen hand at this facility to ensure the special needs of the residents are met.</p>
<p>Standard 1.3.2: Declining</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no</p>

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the service offered, a referral for reassessment is made to the NASC and a new placement found, in consultation with the resident and family/whānau. There is a clause in the admission agreement related to when a resident's placement can be terminated. An electronic system is used as a data base used for all resident information and this is well maintained by management.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale if required, as a means to identify any deficits and to inform care planning. The sample of person centred care plans reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by one of the two trained interRAI assessors on site.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Personal centred care plans evidenced service integration with progress records, activities records, medical and allied health professional's notations clearly written, informative and relevant. Any change of care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</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>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 GP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. Care staff interviewed confirmed that care was provided as outlined in documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the individual residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	FA	<p>The activities programme is provided by two activities coordinators. One coordinator covers the dementia service and the other the rest home and hospital level care residents. A social assessment and history is undertaken on admission for all residents to ascertain each resident's needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly as part of the formal six-monthly person centred care plan review. The families are involved as much as possible for the residents in the dementia service.</p> <p>The planned activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered in all services, for example, special theme and event days, reading, one on one exercise, garden walks, church services, baking sessions and music sessions. The activities programme is discussed at the residents' meetings held two monthly and the minutes indicated that residents' input is sought and responded to. Resident and family interviews demonstrated satisfaction with the activities offered.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at time when residents are most physically active and/or restless. This includes a trolley with planned activities that staff can do with the residents as required.</p>
<p>Standard 1.3.8: Evaluation 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 records. If any change is noted, it is reported to the registered nurse or the clinical manager.</p> <p>Formal person centred care plan evaluations, occur every six months in conjunction with the six monthly interRAI reassessment, or as residents' needs change. Evaluations are documented by the registered nurse (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 behavioural management, post falls, skin tears, pressure injury and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management, were evaluated each time the dressing was changed. Residents and families/representatives interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. The service has two contracted GPs and a nurse practitioner, however, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, a GP sends a referral to seek specialist input. Copies of referrals sighted in residents' records, included, for example, orthopaedic, eye clinic, mental health services for older persons, dietitian and other specialists. Referrals are followed up on a regular basis by the GP. Documentation and interviews verified the resident and the family/representative are kept informed of the referral process. Any acute/urgent referrals are attended to immediately, for example, sending the resident to the DHB if the circumstances</p>

provided to meet consumer choice/needs.		dictate.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read, and are free from damage.</p> <p>Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example, goggles/visors, gloves, aprons, footwear and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</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 displayed. There have been no building modifications since the last audit.</p> <p>There is a planned maintenance schedule implemented. Equipment is available, including shower chairs and sensor alarm mats. There is an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually.</p> <p>Interviews with staff and observation of the facility confirmed there is adequate equipment.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are internal courtyards and grass areas with shade, seating and outdoor tables. There is an internal secure courtyard and external garden area that is secured for residents in the dementia unit. Both have seating and shade.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending</p>	FA	<p>There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p>

<p>to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>Residents and family members report that there are sufficient toilets and showers.</p> <p>Auditors observed residents being supported to access communal toilets and showers, in ways that are respectful and dignified.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Equipment was sighted in rooms requiring this with sufficient space for both the equipment, staff and the resident.</p> <p>Rooms could be personalised with furnishings, photos and other personal adornments and the service encouraged residents to make the suite their own. The dementia unit has bedrooms that are reflective of the lives of the residents.</p> <p>There is space in the bedrooms to store mobility aids, such as walking frames, safely during the day and night if required.</p> <p>Some residents have a larger rooms to accommodate specific aids.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The service has lounge/dining areas, including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents can access areas for privacy. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.</p> <p>There are dining areas in both the rest home and dementia unit with room for residents to mobilise safely. Residents can choose to have their meals in their room.</p> <p>Residents in the dementia unit and rest home are encouraged to join other residents for meals and for social engagement.</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>PA Low</p>	<p>Laundry is completed off site, with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry with separate doors to take clean and dirty laundry in and out. Laundry staff are required to return linen to the rooms. Residents and family members stated that there are issues with personal laundry not always being returned and the time it takes for the laundry to be returned. The healthcare assistants interviewed confirmed knowledge of their role including management of any infectious linen. All chemicals are stored in locked cupboards.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners have a trolley to put chemicals in and the cleaners are aware that the trolley must be with them at all times. This was</p>

		observed in the dementia unit. All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. The cleaner interviewed confirmed that they had training at least annually.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The evacuation plan has been approved by the New Zealand Fire Service. There have been no building reconfigurations since the approval. An evacuation policy on emergency and security situations is in place. A fire drill is undertaken six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures.</p> <p>There is always at least one staff member with a first aid certificate on duty.</p> <p>All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency, including food, water, blankets, emergency lighting and gas barbeques.</p> <p>An electronic call bell system is in place. There are call bells in all resident rooms, resident toilets, and communal areas, including the hallways and dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells. Call bell response times checked by the auditors on the day of the audit confirmed call bells are answered promptly.</p> <p>The doors are locked in the evenings. Staff complete a check in the evening to confirm security measures have been put in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> <p>There is a designated external smoking area for residents should this be required.</p> <p>Family and residents interviewed confirmed the facilities are maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, and input from the clinical manager and the organisation's support management</p>

<p>the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>team. The infection control programme and manual are reviewed annually.</p> <p>The infection prevention and control nurse is an experienced registered nurse. The role and responsibilities of the designated infection prevention and control nurse are defined in a position description. Infection control matters, including surveillance results, are reported monthly to the clinical manager and tabled at the quality/staff meeting. The quality committee includes representatives from all areas of service delivery.</p> <p>Signage at the reception to the facility requests anyone who is, or has been, unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection prevention and control nurse has appropriate skills, knowledge and qualifications for the role, and has been in this role for three years. The infection prevention and control nurse has undertaken Ministry of Health online infection prevention and control training in 2017 and training records verified they have attended additional training related to infection prevention and control. There are well established local networks with the infection control team at the DHB and expert advice from the community laboratory is available if additional support/information is required. The infection prevention and control nurse has access to the residents' records and to diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection prevention and control nurse confirmed the availability of resources to support the programme and any outbreak of an infection. The service has had one major infection outbreak in September 2017. A register was maintained by the clinical manager of all residents and staff affected. No visitors were involved.</p> <p>An outbreak management plan was developed and implemented. A lockdown of the facility was instigated and wings were closed off respectively. The outbreak was 10 days in total and processes were implemented as per policy. Appropriate agencies were contacted at the time and all obligations were met. The infection prevention and control nurse confirmed the availability of resources being available to support the programme and any outbreaks that occur.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard. Policies were last reviewed February 2016 and include appropriate referencing. The kitchen hand, care delivery, cleaning and laundry staff were observed following organisational policies, such as appropriate use of hand sanitises, good hand washing technique and use of personal protective</p>

<p>and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>equipment such as hats, disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses and the infection prevention and control nurse. Content of training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Education for residents is generally on a one-to-one basis and can include for example, reminders concerning hand washing, advice about remaining in their own room if they are unwell, increasing fluids and the cranberry fluid round observed each day in the afternoon.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long-term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include for example, urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented on the infection clinical record. The infection prevention and control nurse reviews all reported infections and maintains a log for each type of infection. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and any required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers observed. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager who reports to the organisation's head office. Data is benchmarked with other facilities. Benchmarking has provided reassurance that infection rates in the facility are below average for the sector.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the</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 provides support and oversight for enabler and restraint management in the facility and demonstrated sound</p>

<p>use of restraint is actively minimised.</p>		<p>understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the day of audit, seven residents were using restraints and four residents were using enablers, which were the least restrictive and used voluntarily at their request.</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, staff interviews and records reviewed of those residents who have been approved restraints.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, made up of the registered nurse (restraint coordinator) and the GP, is responsible for the approval of the use of restraint and the restraint processes, as defined in policy. It was evident from the review of restraint approval group meetings, review of residents' records and interview with the clinical manager, that there are clear lines of accountability, all restraints have been approved and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/EPOA involvement in the decision making, as is required by the organisation's policies and procedures, was recorded in resident files reviewed. The use of restraint or enabler is included in the person centred care planning process and documented in the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator's involvement and input from the resident's family/EPOA. The clinical manager described in interview the documented process. The registered nurses interviewed separately provided a clear understanding of their roles and the processes involved. Families confirmed their involvement. The GP and/or the nurse practitioner has involvement in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome is to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the clinical manager described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as sensor mats and low beds, are explored before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records contain the necessary details, access to advocacy is provided if</p>

		<p>requested and all processes ensure dignity and privacy are maintained and respected. This was verified in the residents' person centred care plans and monitoring forms reviewed.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff interviewed understood that the use of restraints is to be minimised and how to maintain safe use of restraints.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' records evidenced the individual use of restraint is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation includes all requirements of the standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The registered nurses review restraint use three monthly and the restraint/enabler monitoring form is reviewed. The restraint committee undertakes a six monthly review of all restraint use which includes all the requirements of the standard. Six monthly restraint review meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed analysis and evaluation of the amount and type of restraint use in the facility, whether alternatives to restraint have been considered, the effectiveness of the restraint use, the competency of staff and appropriateness of restraint/enabler education and feedback from the GP, staff and families. The six monthly internal audit also informs these meetings. Any changed to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with staff confirmed the use of restraint has been reduced over the past two years.</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 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>Complaints are investigated with documentation evidenced in the complaints files reviewed. Seventeen complaints reviewed from January 2017 to the date of audit, did not consistently have follow up or feedback to families/representatives.</p> <p>Three of seventeen were complaints pertaining directly lack of follow up and feedback.</p>	There is insufficient evidence that action and resolution is communicated to the complainant.	<p>All complaints to be followed up and feedback provided to the complainant.</p> <p>90 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Incidentals and accidents are reviewed and evaluated and documentation of this was evidenced in the resident files reviewed. Three of the families/representatives interviewed stated that their requests for input into care are not always communicated to staff, followed through or acted on and families are not always kept informed.</p>	<p>i) Three of the five families/representatives expressed concern in relation to family requests not always being addressed.</p> <p>ii) Communication is not always effective</p>	<p>i) Ensure all family/representatives requests are followed up.</p> <p>ii) Ensure communication is effective and family are kept informed.</p>

			and families are not always kept informed.	90 days
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	PA Low	<p>The laundry service is contracted out to a laundry service owned and operated by Oceania Healthcare Limited.</p> <p>Interviews with families/representatives and formal complaints identified that missing personal laundry and the time for the laundry to return is a concern.</p> <p>As a result, some families prefer to take personal laundry home.</p>	<p>Personal laundry is not always returned and there is a delay in personal laundry being returned.</p>	<p>The process for the management of personal laundry to be monitored for effectiveness.</p> <p>180 days</p>

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

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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
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End of the report.