

Oceania Care Company Limited - Elmswood Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Oceania Care Company Limited

Premises audited: Elmswood Rest Home

Services audited: Dementia care

Dates of audit: Start date: 28 August 2017 End date: 30 August 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 31

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Elmswood Rest Home can provide care for up to 38 residents with dementia. On the days of the audit there were 31 residents residing at the facility.

This surveillance audit was undertaken to monitor compliance with a sub set of the Health and Disability Service Standards and the district health board contract. The audit process included review of policies and procedures, sampling of residents and staff files, observations, interviews with residents' families, management, staff and a nurse practitioner.

The last certification audit identified improvements required to independence, personal privacy, dignity and respect; communication and complaints, the quality and risk management programme, consumer information and management systems and infection control. The requirements relating to documentation and infection control have been met. The previous requirements for improvement relating to consumer rights and the quality and risk management programme remain open. There are areas identified as requiring improvement at this surveillance audit relating to observations of residents and human resource management system.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights information, the complaints process and the Nationwide Health and Disability Advocacy Service, are accessible. This information is provided to family members upon residents' admission.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Oceania Healthcare Limited has a documented quality and risk management system that supports the provision of clinical care. The business and care manager is responsible for the management of this facility and is supported in their role by a clinical manager.

The facility's clinical indicator data is reported to the Oceania support office monthly. This data is monitored and benchmarked against other Oceania aged care facilities to provide comparisons and to inform staff. Policies and procedures are reviewed at Oceania support office and these are current.

The human resource policies are documented. Staff training and development is conducted and staff review of performance is completed annually.

Healthcare assistants are allocated on each shift to support residents' individual needs. They are supported by registered nurses, diversional therapist, activities coordinator and clinical management staff when this is required. On-call arrangements are known by staff.

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 service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The person centred care plans describe the needs of residents and interventions required. Where progress was different to that expected, the service responds by initiating changes to the care plan or with the use of short-term care plans.

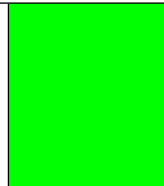
The activities programme includes both planned and spontaneous activities and ensures the activities provided are meaningful to the residents as well as being motivational and enjoyable.

There are processes in place for a safe and appropriate medicine management system. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage.

The food service is managed by the kitchen service manager and kitchen team. The food service plan is displayed. The menus are reviewed by a dietitian every two years. Family interviewed stated their relatives enjoyed the 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.

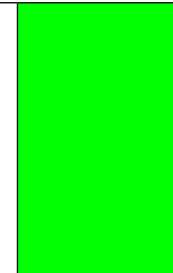


Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures reflect current good practice and meet legislative and Health and Disability Standard requirements. Staff education related to restraint minimisation occurs during orientation and is included in the annual education plan including de-escalation techniques for challenging behavioural episodes. At the time of the audit no restraint or enablers were in use..

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.

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. Surveillance is adequate for the size and nature of this secure dementia service.

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	13	0	2	4	0	0
Criteria	0	38	0	2	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>The organisation's complaints policy and procedure is in line with Right 10 of the Code and includes periods for responding to a complaint. The complaint forms are available at the facility. The complaint management processes are communicated to family members of residents' on entry to the facility.</p> <p>The BCM stated that there had been no complaints with the Health and Disability Commission since the previous audit or with other authorities.</p> <p>The area requiring improvement at the last certification audit relating to the complaints management remains open.</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</p>	<p>PA Low</p>	<p>The previous area identified as requiring improvement relating to loss of residents' personal clothing remains open.</p> <p>All residents' bedrooms are of single occupancy. There are internal and external areas that can be used by residents and family if privacy is required.</p> <p>The staff and management interviewed demonstrated an awareness of residents' rights and the maintenance of professional boundaries. Residents were observed being treated with respect by staff on audit days.</p>

independence.		
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Moderate	<p>The review of residents' clinical files and accident/incident forms evidenced family are notified when adverse events occur. Interview with family confirmed this occurs. This part of the previous requirement for improvement is closed. The area requiring improvement relating to communication between family and the service remains open.</p> <p>There is a documented open disclosure policy and procedure in place to ensure staff maintain open, transparent communication with family members, however, interviews with families confirmed a lack of communication with the service. There was evidence of communication with the nurse practitioner and family.</p> <p>Management and staff advised access to interpreter services is available, if required, via the district health board. Staff and management interviews advised there were no residents who required interpreter services.</p> <p>The facility information pack is provided to family members on residents' admission to the facility. The family members sign an admission agreement on residents' 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>	FA	<p>Elmswood Rest Home is part of the Oceania Healthcare Limited (Oceania). The BCM is a registered nurse (RN) and is responsible for the overall management of Elmswood Rest Home and another Oceania facility. The BCM has previously worked as a BCM in another Oceania facility for eight years prior to commencing employment at Elmswood Rest Home in April 2017. The BCM is supported in their role by the Oceania support office staff. The Oceania clinical and quality manager provided support during this on-site audit.</p> <p>The CM is a RN who has been in this position for 18 months. Both managers undertake education and training relevant to their roles, exceeding eight hours annually.</p> <p>Oceania has a clear mission, values and goals and these are communicated to all concerned.</p> <p>The facility can provide care for up to 38 residents with dementia. On the first day of audit there were 31 residents residing at the facility. The additional service provided at the facility is a residential respite services contract (there were no residents under this contract at the facility on audit days).</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and</p>	PA Moderate	<p>Elmswood Rest Home 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.</p> <p>The Oceania organisational policies and procedures are linked to the Health and Disability Services Standards, current and applicable legislation, and evidenced-based best practice guidelines. There is a system in place for reviewing and updating policies and procedures regularly, including a policy for document</p>

<p>risk management system that reflects continuous quality improvement principles.</p>		<p>update reviews and document control. Staff confirmed that they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery.</p> <p>The quality data reports are communicated to Oceania support office by the BCM and CM. 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. Internal audits are conducted and corrective actions are documented for areas requiring improvement and there is evidence of implementation. Health and safety objectives are recorded and risk registers are documented and reviewed.</p> <p>The facility's meetings have been combined into a monthly quality meeting from April 2017. The quality meeting is open for all staff to attend. This meeting is followed by a general staff meeting. Registered nurses' meetings are conducted monthly with both CMs from Elmswood Rest Home and another Oceania facility, with RNs working in both facilities. The results of the internal audits are communicated to staff via facility's meetings, however, this does not occur consistently. There was evidence of shortfalls in clinical audits not being discussed at clinical meetings. The previous area requiring improvement relating to facility's meetings remains open.</p> <p>The family satisfaction surveys are conducted six monthly. The last satisfaction survey results (February 2017) showed areas requiring improvement relating to: external areas; issues being addressed; activities programme; food service; and laundry. There was no documented evidence of a corrective action plan that has been implemented and no evidence this has been discussed with family and staff. Previous area requiring improvement relating to corrective action plans remains open.</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>	<p>PA Moderate</p>	<p>The management team are aware of the situations/events in which the service would need to report and notify statutory authorities of the events occurring. There were no times since the last audit when authorities have had to be notified, confirmed by management interviews.</p> <p>Staff receive education on the incident and accident reporting process. The staff interviews confirmed their understanding of the adverse event reporting process, however, the neurological recordings were not consistently completed for unwitnessed falls. There was evidence of open disclosure for each recorded adverse event. Family interviews confirmed they are notified when adverse events occur or when the health of their relative changes.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	<p>PA Low</p>	<p>All staff and contractors at the facility, who require professional certificates to practice have current annual practising certificates, as sighted during on-site audit.</p> <p>There are orientation programmes for specific staff roles within the organisation and include the essential</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>components of the services provided. Management and staff interviews stated that all staff complete an orientation programme, however, this was not evidenced in some of the staff files reviewed. The healthcare assistants (HCA) are paired with a senior HCA for shifts or until they demonstrate competency on a number of tasks, including personal cares. Clinical competencies are completed by clinical staff and these are current. There is a staff appraisal process in place and this is up to date.</p> <p>The organisation has a staff mandatory education and training programme that is required under the Age-Related Residential Care Service Agreement and the Health and Disability Services Standards. The staff attendances are documented with all staff completing 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. The interRAI training and competency has been achieved by the CM and one RN. A second RN is in process of interRAI training. The clinical staff have, or are in process of completing, the required dementia training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The 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/or the number of residents.</p> <p>The BCM is responsible for two Oceania facilities and available for Elmswood Rest Home during working hours from Monday to Friday and is on call after hours when required. The CM works Monday to Friday and is on call after hours. There is a RN on duty on morning and afternoon shifts. The lowest number of staff on duty is during night shifts and comprises of three HCAs. Interview with clinical staff confirmed availability of the CM, BCM or a RN from another Oceania facility if the need arises.</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>	<p>FA</p>	<p>The residents' clinical files reviewed evidenced staff names and their designations were consistently recorded in clinical files of residents.</p> <p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical notes were current and integrated with GP and allied health service provider records. Records were legible with the name and designation of the person making the entry identifiable. This was an area of improvement from the previous audit which is closed out.</p> <p>Archived records are retrievable if required. No personal or private resident information was on public display during the audit.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>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>An electronic medication management system is in place. The staff observed demonstrated knowledge and understanding of the 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 medications sighted were within current use by dates. Clinical pharmacist input is provided on a regular basis and six monthly pharmacy audits are performed.</p> <p>All medicines are stored appropriately and fridge temperatures are monitored and are within the recommended range. There were no residents self-administering medications at the time of audit. The medication trolley is locked when not in use and stored in the nurse's station and/or the treatment room.</p> <p>Prescribing in line with best practice was noted, including the management for pro re nata (PRN) medicines. The required three month reviews are consistently recorded on the medicine record.</p> <p>Any medication errors are reported to the clinical manager and recorded on an incident form. The designated family/representative are notified. 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.</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 the kitchen services manager and a team of kitchen staff. Meals are prepared at another site owned by the organisation and meals are transported to Elmswood Rest Home at meal times. The kitchen services manager is a trained chef and has been four years in this role. Kitchen assistants work in three two hour blocks to cover the food service for this facility. Temperature monitoring of the food occurs prior to transportation, on delivery at the facility and prior to serving. The menu plans are reviewed by the organisation's dietitian and this was completed in March 2017. Summer and winter patterns are followed. The dietitian is available on a referral basis.</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. The authorised food safety plan is displayed at the entrance to the facility. The kitchen services manager has undertaken a safe food handling qualification, with kitchen assistants completing 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. Any personal food preferences, special diets and modified texture requirements are make known to the kitchen staff and accommodated in the daily meal plan. There is access to additional food to meet nutritional needs of the residents at all times. Special equipment, to meet residents' nutritional needs, is available.</p> <p>Resident satisfaction with meals was verified by family interviews. At lunchtime the meal service was observed and residents were seen to be given sufficient time to eat their meal and are not hurried. Those requiring assistance had this provided. There is sufficient staff on duty in each of the two dining rooms at meal times to ensure appropriate assistance was available to residents as needed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The family reported that the staff have sound knowledge and care skills. The NP expressed satisfaction with the care provided and stated any medical orders are followed. The provision of services and interventions was clearly demonstrated for the residents' at this secure dementia service. The PCCPs were individualised and personalised to meet the assessed needs of each resident. The care was flexible and focused on quality of life for the residents. There was individualised documented plans on how to manage challenging behaviours over a 24 hour period to meet the specific needs of each resident. The comprehensive behaviour assessments recorded the triggers and de-escalation techniques. Family reported satisfaction with the care and service delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by an activities coordinator four and a half days per week and the weekend activities are provided by a diversional therapist.</p> <p>A recreational assessment and history is undertaken on admission to ascertain residents' needs, previous interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents recreational plans are reviewed six monthly as part of the formal six monthly care plan review and interRAI reassessment process.</p> <p>The planned monthly activities programme sighted matches skills and interests identified in assessment data provided by the family/representative. Activities reflect normal patterns of life and community activities enjoyed by residents with dementia. Individual and regular group events are offered.</p> <p>Activities for the residents in this secure dementia service are organised to meet the abilities of the residents living at this facility. Activities are offered at times when residents are most physically active and/or restless. An activities trolley is available for the evening and night staff to access resources planned on a weekly basis. Twenty four hour activity plans (reviewed) are in place for all residents. The activities coordinator and nursing staff discussed at interview how the planned activities for residents has reduced the need for</p>

		additional (PRN) medication, improved appetites and improved some residents sleep patterns.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress records. If any change is noted, it is reported to the RN and/or the CM. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessment or as residents' needs change. Evaluations are documents by the RN on the evaluation record. Where progress is different from expected, the service responds by initiating changes to the PCCP or with the use of a short-term care plan. Examples of short-term care plans were reviewed (e.g. wound care, urinary tract infections, skin tears or post falls). The progress was evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Family interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The facility has a current building warrant of fitness. There have been no alterations to the building since the last audit.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observations 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 control nurse. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. The infection control nurse has completed infection control education. The care staff and RNs attend the annual study days run by the organisation. This was verified in the training records. The previous requirement for improvement is closed.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives,	FA	The service conducts monthly surveillance for infections. The service uses standardised definitions of infections that are appropriate to the long-term care setting. The surveillance data is analysed, reviewed, trended and externally benchmarked. When trends are identified, these are discussed at the quality meeting and additional actions are discussed and implemented. Surveillance is adequate for the size and complexity

<p>priorities, and methods that have been specified in the infection control programme.</p>		<p>of this secure dementia service.</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>Restraint is minimised at this secure dementia service. At the time of the audit the restraint register identifies that there are no restraints or enablers being used.</p> <p>Policy identifies that an enabler is voluntary and the least restrictive option to keep a resident safe. All documentation is in place to meet legislative requirements should this be required for a resident.</p> <p>Staff interviewed are aware of the difference between an enabler and a restraint and what actions need to be taken related to their use. Restraint and behavioural management is included in the staff orientation/induction processes. Ongoing education is identified on the staff education calendar sighted.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>The complaint process is communicated to the family members on residents' admission to the facility and is part of the facility's information pack. The CM is responsible for complaints management and is supported by the BCM.</p> <p>The complaints register reviewed for 2017 recorded seven complaints. Not all of the complaints were responded to within the required timeframe. There was no recorded evidenced the process of complaint management or advocacy support was communicated to the complainant in all seven complaints documentation. The investigations relating to some complaints did not consistently evidence a robust and detailed investigation was carried out. The complainants' satisfaction of the resolution was not always recorded.</p> <p>Interviews with family referred to complaints that were not included in the complaints register. Interview with family members confirmed verbal and written complaints are not always followed up (refer to 1.1.9.1).</p>	<p>The complaints register is not up to date and the complaints process does not comply with the Right 10 of the Code.</p>	<p>Provide evidence the complaints register is up to date and the complaints process complies with Right 10 of the Code.</p> <p>90 days</p>

<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	<p>PA Low</p>	<p>Family interviews confirmed staff have been informed of missing residents' belongings on a number of occasions, however, this is not consistently recorded and/or investigated. The complaints register evidenced two complaints relating to loss off clothing, however, family interviews confirmed other clothing has gone missing and this was not recorded in the complaints register (refer to 1.1.13.3). The family members also confirmed the residents' personal clothing is named and some residents' belongings have returned to them after a number of months having been misplaced.</p> <p>The laundry (including residents' personals) is conducted at another facility located across the road from Elmswood Rest Home. Interview with the business and care manager (BCM) confirmed awareness of the long standing issues of residents' belongings going missing. The BCM stated a new process has been implemented in the laundry, ensuring the laundry received from Elmswood Rest Home is done separately from the other facility's residents' clothes. This has not reduced the items going missing.</p> <p>The clinical manager (CM) implemented a daily check of residents' rooms, to check on resident's clothes being in the right bedrooms. The checklists sighted evidenced this is not consistently completed. The CM stated this had not reduced the issue of the missing items.</p> <p>Healthcare assistant (HCA) interviews confirmed some residents' clothes are found to be located in other residents' rooms. At times residents wear other residents' clothes, confirmed by both staff and family interviews.</p>	<p>Residents' belongings are going missing and the service is not able to track/find the missing items.</p>	<p>Provide evidence residents' belongings are cared for in a safe and appropriate manner.</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>	<p>PA Moderate</p>	<p>The family members interviewed stated (three of six) they do not consistently receive information relating to certain areas of services provided, such as missing belongings (refer to 1.1.3.1). The residents' meetings are held monthly, however, the family members interviewed stated they were not aware of when these meetings are held or that they can attend. They have not attended any facility's meetings. Family members also confirmed that they do not receive</p>	<p>Family interviews confirmed a lack of communication with service providers.</p>	<p>Provide evidence that full, frank and open disclosure of information and communication is upheld at the facility.</p>

		<p>any newsletters/communication from the facility.</p> <p>The information pack sighted, includes but is not limited to, information relating to the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code); complaints management; and the facility's information and philosophy. However, there was no information relating to the need for a safe environment or how challenging behaviours are managed and restraint is minimised (ARC E4.1b).</p>		60 days
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>The facility's meeting minutes evidenced the discussion at meetings was limited and did not always include all quality data that is required to be communicated to staff, for example results of any shortfalls of internal audits.</p>	<p>Not all meeting minutes are comprehensive enough to reflect the content and outcomes of the meetings and records evidence quality data is not consistently discussed at meetings.</p>	<p>Provide evidence the meeting minutes are comprehensive and all required quality data is discussed.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA</p> <p>Moderate</p>	<p>The last satisfaction survey results (February 2017) showed areas requiring improvement relating to: external areas; issues being addressed; activities programme; food service; and laundry. There was no documented evidence of a corrective action plan that has been implemented and no evidence this has been discussed with family and staff.</p> <p>Review of internal audits and accident/incident forms evidenced the areas identified as requiring improvement have documented corrective action plans are these are implemented and signed off. The previous area requiring improvement relating to the incidents/accidents and internal audits not consistently providing appropriate corrective actions plans has been met.</p>	<p>There is no recorded evidence of a corrective action plan and its implementation, or communication to staff and family following a family satisfaction survey.</p>	<p>Provide evidence when areas requiring improvement are identified by family satisfaction surveys, a corrective action plan is developed and implemented and results are communicated to all concerned.</p>

				90 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 Moderate</p>	<p>The accident and incident forms reviewed evidenced the family, manager and the general practitioner (GP) (when required) have been notified of the adverse events occurring. Review of fifteen accident/incident forms was conducted and evidenced the residents who sustained unwitnessed falls did not have neurological recordings conducted (four of fifteen) or when the neurological observations were completed, the frequency and the timeframe of the observation were not conducted as required (eight of the fifteen).</p>	<p>The neurological recordings were not always commenced or fully completed when required following residents' unwitnessed falls.</p>	<p>Provide evidence neurological recordings are completed when required.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>Staff orientation is conducted, as confirmed by staff and management interviews. The staff files reviewed evidenced not all required information was located in the files such as: application; job descriptions; police checks and evidence of orientation.</p>	<p>Staff files did not consistently evidence orientation completion or other relevant information.</p>	<p>Provide evidence that the staff files contain all relevant information of the staff members according to human resource management processes, best practice and legislative requirements.</p> <p>180 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.