

Oceania Care Company Limited - Ohinemuri Rest Home and Village

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:

Legal entity:	Oceania Care Company Limited
Premises audited:	Ohinemuri Rest Home and Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 9 October 2018 End date: 10 October 2018
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:	63

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

Ohinemuri Rest Home and Village is part of Oceania Healthcare Limited. The service provides residential care for up to 68 residents. Occupancy at the time of the on-site audit was 63 residents.

The audit was conducted against the Health and Disability Sector Standards and the contractual agreement with the district health board.

This audit process included review of policies and procedures, review of resident and staff files, and observations and interviews with residents, family, management, staff and a general practitioner.

The 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 is an improvement required in relation to meeting timeframes for service delivery.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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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 at the facility. This information is brought to the attention of residents and their families on admission to the facility.

Residents confirmed their rights are being met, staff are respectful of their needs and communication is appropriate.

The service has a documented complaints management system and a complaints register is maintained.

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 for Ohinemuri Rest Home and Village and is responsible for the services provided.

There have been no changes to the staffing structure or systems since the previous audit. The business and care manager has been in their position for just over a year. The business and care manager is a registered nurse who is suitably qualified and experienced for the role. The business and care manager is supported by a clinical manager, with additional support from the regional clinical quality manager.

The clinical manager is also a registered nurse and responsible for clinical management and oversight of services. The clinical manager is supported by registered nurses and the regional clinical quality manager.

The service has a planned, documented quality and risk management system that supports business management and provision of care. Quality and risk performance is reported through meetings and monitored through the business status reports and operations reports. The quality programme includes an internal audit programme, education and training, meetings, incident and accident monitoring, and management of complaints, infection control, restraint and health and safety.

The facility uses the company-wide electronic system to record and monitor key quality indicators and organisational performance.

Human resource policies and procedures guide practice. Annual practising certificates for personnel who require them to practise are current. In-service education is provided for staff, including compulsory training around clinical service delivery. Review of staff records provide evidence that human resource processes are being followed.

Staffing levels are adequate across the service. Registered nurses are on duty 24 hours, 7 days per week and are supported by appropriate levels of care and allied health staff. There are at least two staff with current first aid certification on duty at all times.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents are assessed prior to entry to the service. Initial nursing and medical assessments, and initial nursing care plan are completed upon the resident's admission. Registered nurses are responsible for nursing assessments and care plan development

and review, with input from residents and family. The residents' files provided evidence of documented residents' needs, goals and outcomes. Residents' short-term care plans for acute conditions are completed whenever a short-term problem is identified.

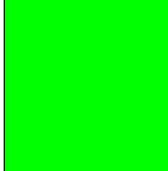
Planned activities are appropriate to the residents' assessed needs and abilities and the activities programme includes a wide range of activities and involvement with wider community. Individual activities are provided either within group settings or on a one-on-one basis. Residents with dementia have individualised 24 hour activities care plans completed.

Residents are referred or transferred to other health services as required, with appropriate verbal and or written communication occurring.

Medications are managed and administered in line with legislation and current regulations and guidelines. Staff responsible for medicine management have current medication competencies. The residents self-administering medicines do so according to policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are met. The menu has been reviewed by a dietitian as meeting nutritional guidelines for older people. Residents requiring special dietary requirements and need for feeding assistance or modified equipment have these met. There is a central kitchen and on site staff that provide the food service. The residents verified satisfaction with meals.

Safe and appropriate environment

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

All rooms provide single accommodation. There are eight rooms with ensuite bathroom facilities. Bathroom and showering facilities are provided throughout the facility and are easily accessible.

Residents' rooms are spacious enough to allow for the safe use of mobility aids and staff. There are several lounges and dining areas throughout the facility with internal courtyards and external areas providing seating and shade. The service has an appropriate call bell system with a security system to ensure resident safety.

Waste is segregated and disposed of according to policy and legislative requirements. Staff are educated to handle waste safely. Hazardous substances and chemicals are stored appropriately.

The facility has a current building warrant of fitness and a preventative maintenance programme to ensure the building, utilities and equipment comply with the regulations and safety requirements. Residents' rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Oceania Healthcare Limited has developed and maintained plans to respond to emergency situations, including fire and medical emergencies. Exercises for disaster response and evacuation of buildings are held and staff are trained. There is emergency equipment and supplies available on site in the event of an emergency.

Cleaning and laundry systems include appropriate monitoring systems through the internal audit process.

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 Oceania Healthcare Limited restraint policy includes documented enabler and restraint procedures. The definitions of restraints and enablers align with the definition in the standards. The approval process for enabler use is activated when a resident

voluntarily requests an enabler to assist them to maintain independence and/or safety. There were no residents requiring restraints or using enablers on audit days. Staff are trained in restraint minimisation and challenging behaviour management.

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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Infection prevention and control management systems are in place to minimise the risk of infection to residents, staff and visitors.

The Oceania infection control programme is implemented and meets the needs of the organisation. An infection control nurse is responsible for this programme, including education and surveillance.

Documentation evidenced that relevant infection control education was provided to all staff as part of their orientation and as part of the ongoing in-service education programme. Staff are familiar with infection control measures at the facility.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to through all levels of the organisation, including governance. Infection control data is benchmarked against other Oceania facilities.

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	44	0	0	1	0	0
Criteria	0	92	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ohinemuri Rest Home and Village is guided by Oceania Healthcare Limited's overarching policies, procedures and processes to meet its obligations in relation to the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code).</p> <p>Staff interviewed demonstrated knowledge, understood the requirements of the Code and were observed demonstrating respectful communication, open disclosure, encouraging patient independence, providing options and maintaining residents' dignity and privacy.</p> <p>The Code is a component of the staff induction process and the education planner reviewed evidenced ongoing education on the Code is provided.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. Residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of their care.</p> <p>All resident files identified that informed consent is collected. Interviews with staff confirmed their understanding of informed consent processes.</p> <p>The service information pack includes information regarding informed consent. The pack also</p>

		<p>includes specific information on dementia care and what this involves. The RN or the CM discusses informed consent processes, with residents and their families/whānau, during the admission process.</p> <p>There is a policy and procedure which includes guidelines for consent for resuscitation/advance directives. A review of files noted that all residents had appropriately signed advanced directives.</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>	FA	<p>Information on advocacy services is available at the entrance to the service along with nationwide advocate details. Information on advocacy services through the Health and Disability Commissioner's Office is provided to residents and families. The admission pack reviewed included advocacy, complaints and Code of Rights information as well as advanced care planning.</p> <p>There are policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates when needed. The role of advocacy services is included in training on the Code which is provided annually to staff.</p> <p>Discussions with families and residents identified that the service provides opportunities for the family or EPOA to be involved in decisions. Resident files included information on residents' family/whānau and chosen social networks. Residents and family interviewed confirmed that advocacy support is available to them if required, including information on how to access a Health and Disability advocate.</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>	FA	<p>Residents may have visitors of their choice at any time. Families confirmed they could visit at any time and are always made to feel welcome. Afterhours visitors can use the bell at the entrance to notify staff they require access.</p> <p>Residents, including YPD, are encouraged to be involved in community activities and to maintain networks with family and friends. Residents' files reviewed and handover 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</p>	FA	<p>The 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. The complaints register is in place and the register includes: the date the complaint is received; the</p>

<p>complaint is understood, respected, and upheld.</p>		<p>source of the complaint; a description of the complaint; and the date the complaint is resolved.</p> <p>Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner. Staff, residents and family confirmed they knew the complaints process. Evidence relating to each lodged complaint is held in the complaints folder and register. Staff, residents and family confirmed they knew the complaints process.</p> <p>The BCM is responsible for managing complaints. Residents and family stated that complaints are dealt with as soon as they are identified. Residents and family members were able to describe their rights and advocacy services particularly in relation to the complaints process.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The business and care manager (BCM) and the clinical manager (CM) discuss the Code with residents and their family during the admission process. Discussion relating to the Code is also included on the agenda and discussed at residents' meetings.</p> <p>Interviews with residents and families 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. Posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English.</p> <p>The completed resident and family surveys indicated residents are aware of their rights and are satisfied with this aspect of service delivery.</p> <p>Residents interviewed confirmed they had access to an advocate when needed.</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>	<p>FA</p>	<p>The service 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. Conversations of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings.</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. Policy and guidelines provide strategies for the management of inappropriate behaviour.</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</p>

		<p>in the resident's room and there are areas in the facility which can be used for private meetings.</p> <p>Health care assistants (HCA) report 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 quality care. Staff receive annual training on abuse and neglect and can describe how to recognise this. There are no documented incidents of abuse or neglect in the business status reports or on the incident/accident forms reviewed in residents' files. Residents, staff, families and the general practitioner (GP) confirmed that there was no evidence of abuse or neglect.</p> <p>Resident files reviewed, including a file for a young person with disabilities (YPD), confirmed that 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>	<p>FA</p>	<p>The service implements the Māori health plan and cultural safety procedures to eliminate cultural barriers.</p> <p>The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. The service has links to local kaumātua and Māori services are through the district health board.</p> <p>There are staff who identify as Māori and staff report that specific cultural needs are identified in the residents' care plans. There are Māori residents currently using the service. A resident who identifies as Māori confirmed in interviews that their cultural needs are well catered for. The file reviewed of a resident who identifies as Māori confirms that there is a cultural assessment with the plan including cultural needs.</p> <p>Staff are aware of the importance of whānau in the delivery of care for the Māori residents.</p> <p>Cultural training for staff is provided as part of the annual training programme. Health care assistants confirmed an understanding of cultural safety in relation to care. The activities coordinator (AC) completes cultural assessments on admission and cultural needs are also addressed in activity plans which are reviewed six monthly.</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>	<p>FA</p>	<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 choices in meals and activities.</p> <p>Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the resident's cultural values and beliefs. This information is used to develop a care plan.</p> <p>There is a focus on ensuring that activities for younger residents are relevant to their abilities and cultural needs. The ACs and each individual resident work to identify individual activities that are meaningful to them and which encourage independence. This includes activities promoting independence for residents in the dementia unit.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<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 relevant to the role held by the staff member. The orientation and employee agreement provided to staff on induction include standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the HCAs' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Policies are based on current good practice and are aligned with legislative requirements and guidelines. Staff described in interviews practices based on policies and procedures. Staff have access to information on good practice provided by governing bodies and specialists in the region.</p> <p>There is a staff education programme. Training is provided by specialist educators as part of the in-service education programme. Registered nurses (RN) attend compulsory education at the district health board (DHB) and complete the professional development and recognition programme through the DHB.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The accident/ incident policy, 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. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms.</p> <p>Family contact is recorded in residents' files. Interviews with family members confirm they are kept informed. Family also confirmed that they are invited to the care planning meetings for their family member and could attend the resident meetings.</p> <p>Residents are expected to 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.</p> <p>Staff are familiar with how translating and interpreting services can be accessed. There were no residents at the time of audit requiring interpreting services.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Ohinemuri Rest Home and Village is part of Oceania Healthcare Limited with the executive management team providing support to the service.</p> <p>The BCM is a registered nurse and has been working in New Zealand since 2012. The CM is responsible for overseeing clinical matters. The CM has been in this role for two and a half years and previously worked in the facility as a registered nurse for 22 years. The facility management team is supported by the regional clinical quality manager who was present during the on-site audit.</p> <p>The BCM provides monthly status reports to the support office. Reports include quality and risk management issues, occupancy numbers, human resource issues, quality improvements, internal audit outcomes and clinical indicators.</p> <p>Communication between the facility and executive management takes place on a monthly basis. The monthly business status report provides the executive management with progress against identified indicators. The organisation has systems in place documenting the scope, direction and goals of the organisation, including a business plan, a quality plan, risk register and the current budget.</p> <p>The mission, values and goals are documented. These are communicated to residents, family and staff through posters on the wall, information in booklets and in staff training provided annually. The facility can provide care for up to 68 residents. This includes 22 hospital, 34 rest home (inclusive of 10 dual purpose beds), and 12 dementia.</p>

		Occupancy was 63 residents of which 18 residents were receiving hospital level care. At rest home level, there were 34 residents, including 1 resident receiving respite care and 1 resident under 65 with physical disabilities receiving care under the long-term support chronic health conditions contract. There were 11 residents receiving dementia level of care.
<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>The service has appropriate systems in place to ensure the day-to-day operations of the service continues should the BCM or the CM be absent. The CM, with support from the regional clinical quality manager, stands in when the BCM is absent. The BCM stands in for the CM when away and there is support from an administrator.</p> <p>Both the BCM and CM are on call after hours if required. Oceania support office provides additional assistance when needed. Job descriptions and interviews with the BCM and CM confirmed their responsibility and authority for their roles.</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>Ohinemuri Rest Home and Village uses the Oceania Healthcare Limited quality and risk management framework.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are current and subject to reviews as required. The support office reviews all policies, with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to confirm that they have read and understood the policies. Staff interviewed stated they read any new or revised policies and all sign a form indicating that they have read and understood policies. All clinical staff interviewed reported they are kept informed of quality improvements.</p> <p>There are monthly joint staff/quality and joint health and safety/infection control meetings held. The meetings include all aspects of the quality programme. There are monthly resident meetings with family able to attend if they choose to.</p> <p>Service delivery is monitored through review of complaints, review of incidents and accidents with monthly analysis of data, surveillance of infections, and implementation of an internal audit programme. Corrective action plans and evidence of resolution of issues are documented when these are identified.</p> <p>Risks are identified. There is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks</p>

		<p>and clinical risk.</p> <p>Resident/family satisfaction surveys are completed six monthly. Results documented from the August 2018 survey indicated that residents and family are satisfied with the service and environment with minimal suggestions for improvement.</p> <p>Interview with the YPD confirmed their participation in decision making, having access to technology and the equipment they may need.</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>Staff document adverse, unplanned or untoward events on an accident/incident form. Families are being informed after adverse events, confirmed in clinical records and during family and resident interviews. Accident/incident forms are reviewed and signed off by the BCM. Corrective action plans address areas requiring improvement and are documented. There is an open disclosure policy.</p> <p>The BCM is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles. Policy and procedures include requirements for essential notification and reporting for example how and where to report infectious outbreaks. There has been no essential notifications or adverse events reported to external agencies.</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for documenting adverse events and their responsibilities relating to essential notification through: job descriptions, policies and procedures.</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>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and authority. These were evidenced in staff files along with employment agreements, reference checking, criminal vetting, drug testing, and completed orientations and competency assessments.</p> <p>Copies of annual practising certificates are reviewed for all staff that require them to practise and were current. The CM is responsible for the in-service education programme. Competency assessment questionnaires are available and completed competencies were reviewed. Staff are supported to complete education via external education providers. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.</p>

		<p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. Orientation for staff covers the essential components of the service provided. The BCM advised that staff complete orientation and induction at employment. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Care staff interviewed confirmed they have completed an orientation, including competency assessments. Unit standards specific to dementia modules are included in the study days for staff, especially those who work in the dementia unit. The service has seven registered nurses who have completed InterRAI 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>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse cover is 24 hours a day.</p> <p>There are 73 staff, including the management team, clinical staff, ACs, and household staff. There is a RN on each shift. Residents and families confirmed staffing is adequate to meet the residents' needs. 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. The staffing policy is the foundation for workforce planning.</p> <p>Rosters showed that staffing levels meet resident acuity and bed occupancy.</p> <p>On call after hours RN support and advice is provided by the BCM and CM. Care staff interviewed reported adequate staff is available and that they are able to get through their work. Residents and family interviewed reported staff provide them with adequate care.</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 retains relevant and appropriate information to identify residents and track residents' records. This includes information collected on admission with the involvement of the family. There is sufficient detail in resident's files to identify resident's ongoing care, history, and activities. Documentation in individual resident files demonstrated service integration. The resident's national health index number, name, date of birth and general practitioner are used as the unique identifier. Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information.</p> <p>Residents' information is stored securely in staff areas. Clinical notes are current and accessible to all clinical staff; documentation containing sensitive resident information is not displayed in a way that it could be viewed by other residents, clinical or care staff, or members of the public. Entries are legible, dated and signed by the relevant HCA, RN or other staff</p>

		member, including designation. Approved abbreviations are listed. Resident records pertaining to service delivery are integrated.
<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 are assessed prior to entry to the service by the needs assessment coordination service (NASC). Each potential resident who may be admitted to the facility is assessed using the interRAI home care assessment tool in the six months before the date of their admission. The residents' files evidenced this is occurring. The needs assessments are completed for rest home, hospital and dementia levels of care. The prospective residents and/or their families are encouraged to visit the facility prior to admission. The service has specific information available for residents and family prior to entry and upon admission.</p> <p>The organisation obtains information from the NASC service and/or the GP for residents accessing respite care.</p> <p>The residents' admission agreements evidence resident and /or family and facility representative sign off. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.</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>A transfer notification form is used when residents are required to be transferred to the DHB or to another service. The residents and their families were involved for all exit or discharges to and from the service.</p> <p>Family communication forms, transfer forms and progress notes in residents' clinical files demonstrated transition, exit, discharge or transfer plans are communicated with families and other providers, when required. At the time of transition, appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the residents' clinical files.</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 policies and procedures comply with current legislation and guidelines. The service uses an electronic/computerised medication management system. Medicines are appropriately stored in accordance with relevant guidelines and legislation and evidenced weekly checks and six monthly physical stock takes. Regular records of temperature checks for the medicine fridge have readings documenting temperatures within the recommended range.</p>

		<p>Medication administration practice complies with the medication management policy. A medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and signed off as the dose was administered. All staff that administer medicines are assessed as competent and have received medication management training.</p> <p>Four residents self-administer their own medicines. Documentation reviewed evidenced residents' competency to self-administer medicines was recorded and policy on self-administration was followed.</p> <p>Medication errors are reported to the RN and recorded on an incident form. There is a process for analysis of any medication errors, and compliance with this process was verified.</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 service operates with a multi-site approved food control plan applicable to all Oceania facilities. The registration expiry date of the food control plan is March 2019. The four weekly rotating menu is in line with recognised nutritional guidelines for older people and had been reviewed by a dietitian.</p> <p>Part of resident's initial assessment on admission to the facility includes a dietary assessment. The personal food preferences of the residents, special diets and modified nutritional requirements are recorded on a resident's dietary profile and communicated to the food service staff. The cook stated the residents' dietary preferences and allergies are catered for and accommodated in the daily meal plans. Special equipment, to meet residents' nutritional needs, was sighted. The residents' dietary requirements are reviewed on a regular basis.</p> <p>All meals are prepared and cooked on site in the kitchen and served to residents in dining rooms. For those residents who prefer or require to have their meal in their room, meals are plated, covered and transported to residents' rooms. Staff were observed assisting residents with their meals and drinks.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weight, more frequently if required and as directed by a GP/dietitian. Supplements are provided to residents with identified weight loss issues. The residents' in the dementia unit are provided with snacks 24 hours a day.</p> <p>Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services. Residents and family members interviewed indicated satisfaction with the food service and reported their individual preferences were met and adequate food and fluids were provided.</p>

		<p>Food temperatures are monitored appropriately and recorded as part of the food control plan. The food service staff have undertaken a safe food handling qualification and completed all relevant food handling training. All food observed in the fridges and freezers was dated.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p>
<p>Standard 1.3.2: Declining 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>	FA	<p>The reason for declining entry to residents would be recorded, and when this has occurred, the management stated it had communicated to the resident/family and the appropriate agencies. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.</p> <p>Residents would be declined entry if not within the scope of the service or if a bed was not available, as confirmed at management interviews.</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>Residents are admitted with a care needs level assessment completed by the NASC team prior to admission. Resident's needs and personal information is gathered during admission through a variety of sources to establish an initial care plan. The residents' files evidenced residents' completed discharge/transfer information from the DHB where required. The interRAI assessment tools are not always completed within the required timeframes (refer to 1.3.3.3).</p> <p>Residents' assessments are conducted in a safe and appropriate setting, including visits from the GP and specialists. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</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>The RNs are responsible for all aspects of care planning. Each resident has a long-term nursing care plan based on assessments. The care plans reviewed demonstrated service integration, input from allied health staff and individualised interventions for all identified care needs. The care plan interventions reflect the risk assessments and the level of care required. Short-term care plans are developed when required and signed off by the RN when short-term problems are resolved.</p> <p>Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Family members interviewed confirmed the care delivery</p>

		<p>and support by staff is consistent with their expectations.</p> <p>In interviews, staff reported they receive adequate information for continuity of residents' care.</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 documentation, observations and interviews verified the provision of services was consistent with the residents' needs and their desired outcomes. The residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents. Staff confirmed in interviews they were familiar with the current interventions of the residents they were allocated. Nursing progress notes and observation charts are maintained, recording sufficient information for provision of care. Interviews with RNs, CM and HCAs demonstrated their understanding of the individualised needs of residents.</p> <p>The facility has appropriate resources and equipment, confirmed at staff interviews and visual observation. The equipment available complied with best practice guidelines and met the residents' needs. Staff reported they have access to sufficient medical supplies. Sufficient continence products are available and residents' files included a continence assessment and plan.</p> <p>Wound monitoring and wound management plans were in place for seven wounds. Wound documentation includes assessment and monitoring forms with recorded timeframes for review. The wound management plans include sufficient detail to direct treatment. The RNs have access to specialist nursing wound care management advice through the DHB.</p> <p>Family communication is recorded in the residents' files. In interviews, residents and family confirmed current care and treatments meet their needs.</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>There are three ACs providing the recreational programme at the facility. One of the AC staff stated they were training as a diversional therapist. The programme is provided seven days a week. In interviews, the ACs confirmed the activities programme meets the needs of the service group and the service has appropriate equipment. Residents were observed participating in activities on the days of audit.</p> <p>The residents are assessed by the ACs to ascertain their social needs and appropriate activity and social requirements. The residents' activities assessments are analysed to develop an activities programme that is meaningful to the residents. The monthly activities programme is signed off by a diversional therapist at another Oceania facility.</p> <p>The activities programmes include input from external agencies and supports ordinary</p>

		<p>unplanned/spontaneous activities including festive occasions and celebrations. The weekly activities planned are displayed on a noticeboard at the entrance to the facility and daily in the dementia unit.</p> <p>There were current, individualised activities care plans in residents' files reviewed. The residents' activity needs are evaluated as part of the formal six monthly care plan review for the rest home and the hospital residents. The residents in the dementia unit had 24 hour activities care plans completed, however, the six monthly reviews were not always completed (refer to 1.3.3.3).</p> <p>Resident meetings provide a forum for feedback relating to activities. Family/whānau and friends are welcome to attend all activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Timeframes in relation to care planning evaluations are documented and implemented. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals, are carried out by the RNs and documented on the care plan evaluation form. InterRAI reassessments are completed six monthly or when changes in resident's health status occurs.</p> <p>There was evidence of resident, family, RN, HCA, AC and GP input into care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews. The residents' care plans were up to date and reviewed six monthly (refer to 1.3.3.3).</p> <p>The residents' progress notes have entries by clinical staff on each shift and there is evidence residents' care is evaluated and reported on. If any change is noted it is reported to the RN. When resident's progress is different than expected, the RN contacts the GP as required, confirmed at GP interview.</p> <p>Short-term care plans were in some of the residents' files and used when required. Short-term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. The family are notified of any changes in resident's condition, as confirmed at family interviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents and/or their family are involved as appropriate when referral to another service occurs. Family communication sheets confirmed</p>

<p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>family involvement.</p> <p>When required, referrals to non-urgent services are conducted by the GP or the RN. Referrals are followed up on a regular basis by the GP or the RN. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. The GP interview confirmed they are informed of any acute changes in resident's condition and involved in acute referrals to DHB.</p>
<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>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place and the hazard register is current. Policies and procedures for chemicals specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage.</p> <p>Material safety data sheets are available throughout the facility and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Interviews with the household staff confirmed this. Incidents and accidents are reported on in a timely manner.</p> <p>There is provision and availability of personal protective clothing and equipment including: goggles/visors; gloves; aprons; footwear; and masks. During a tour of the facility, personal protective clothing and equipment was observed in areas where there are risks.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed. The service has a planned maintenance schedule implemented with a test and tag programme. Checking and calibration of clinical equipment is completed annually.</p> <p>There has been recent refurbishment of resident rooms and there has been no building modifications since the last audit. Interviews with staff and observation of the facility confirmed there is adequate equipment including: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats.</p> <p>There is an outside area with shade, seating and outdoor tables. There are ramps and rails at entrance doors for access for residents with disabilities. The dementia unit provides secure and appropriate external areas for residents. The service provides mobility access throughout the facility, meeting requirements for YPD.</p> <p>Hot water temperatures are monitored at monthly intervals and is delivered in line with the</p>

		recommended temperature range. Interviews with the maintenance person confirmed that if the hot water temperatures exceed the recommended temperatures, corrective action is taken to address the issue.
<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 to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Visual observation provided evidence that toilet; shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Visitors' toilets and residents' toilets are located close to communal areas. All the toilets have a system that indicates if it is engaged or vacant.</p> <p>All the residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence.</p> <p>Residents and family members report that there are sufficient toilets and showers with some rooms in the rest home/hospital area having their own ensuite. 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>	FA	<p>There is adequate personal space in all the bedrooms to allow residents and staff to safely move around in the room.</p> <p>Equipment was sighted in hospital rooms needing this, with sufficient space for both the equipment and at least two staff and the resident, for example, hoists and wheel chairs. The residents' rooms are individualised with furnishings, photos and other personal possessions. Residents are encouraged to make the room their own.</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>	FA	<p>The service has lounges and dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Visitors and residents, including YPD, are able to access areas for privacy, when required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely. There is furniture in the garden areas and designated parking spaces for the mobility scooters.</p>
<p>Standard 1.4.6: Cleaning And Laundry</p>	FA	<p>Laundry services are completed on site. 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</p>

<p>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>required to return linen to the rooms. The linen trolleys are clearly labelled to identify resident's individual laundry and general laundry. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week.</p> <p>The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. Cleaners were observed on the days of the audit keeping the cleaning trolley in sight. All chemicals are in appropriately labelled containers. Laundry chemicals are administered through a closed system which is managed by a chemical contractor company. Products are used with training around use of products provided.</p> <p>Residents and families stated they were satisfied with the cleaning and laundry services.</p>
<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>	<p>FA</p>	<p>The service has documented systems in place for essential, emergency and security services. Registered nurses, healthcare assistants, the ACs and the people who drive the van with residents in it, are required to complete first aid training. There are at least two designated staff members on each shift with appropriate first aid training. Emergency and security management education is provided at orientation and at the in-service education programme. Staff records sampled provided evidence of current training regarding fire, emergency and security education.</p> <p>An evacuation plan has been approved by the New Zealand Fire Service. Fire drills are completed six monthly. Checking the fire exits daily for clearance is on the maintenance daily schedule. Staff confirmed their awareness of emergency procedures. 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. Information in relation to emergency and security situations is readily available/displayed for staff and residents. Emergency equipment is accessible, current and stored appropriately with evidence of emergency lighting, torches, gas and barbeque for cooking, extra food supplies, emergency water and blankets.</p> <p>The service has a call bell system in place that is used by the residents, family and staff members to summon assistance. All residents have access to a call bell. Call bells are checked monthly by the maintenance person. Residents confirmed they have a call bell and staff respond to it in a timely manner.</p> <p>Security systems include security lighting and external doors being locked after sunset. Staff complete security checks at set intervals at dusk and dawn and once or twice during the night.</p>

		<p>Families and residents, including YPD, know the process of alerting staff when in need of access to the facility after hours.</p> <p>There are documented visitors' policy and guidelines available to ensure resident safety and wellbeing is not compromised by visitors to the service. Visitors and contractors are required to sign in and out of visitors' registers.</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. Monthly room temperature checks are monitored.</p> <p>Family and residents stated that the building is maintained at an appropriate temperature in both winter and summer.</p> <p>There are designated smoking areas for the staff and residents.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Oceania infection control policies and procedures manual is current. This manual guides staff in infection prevention and control with the required policies under this standard. The Oceania infection control committee (company-wide) has defined terms of reference. The infection prevention and control programme is reviewed annually by the regional clinical and quality managers.</p> <p>An RN is the designated infection control nurse (ICN) with support from the CM. Infection control audits are conducted as per the internal audit schedule and include hand hygiene and infection control practices.</p> <p>There was evidence of measures in place to ensure staff, residents and visitors do not expose other to infections when they are unwell. Staff understand the requirements of infection control measures including not reporting for work when unwell. Residents are isolated when infectious and visitors are alerted not to visit the facility when suffering from infections. Hand hygiene posters are displayed as are hand gels available for use on entry to the facility and throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>Interview with the ICN confirmed they have specific hours allocated for this role. The role description for this position was signed.</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>There are adequate resources to implement the infection control programme at the facility. There are Oceania and external support systems available if required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention 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>FA</p>	<p>There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual includes a range of policies, standards and guidelines which complies with legislation and current accepted good practice. The policies have been reviewed and are current.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>New staff receive education in infection prevention and control at orientation. Infection prevention and control ongoing education is provided as part of the mandatory study days. The ICN has completed relevant infection control training. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is part of the infection prevention and control programme and is described in the infection control manual.</p> <p>The ICN and RNs maintain infection logs for residents' infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short-term care plans in place. The GP is informed in timely manner when a resident has an infection and appropriate antibiotics are prescribed.</p> <p>Monthly infection data is collected for all infections based on signs and symptoms of infections. This information is entered in the clinical indicators on the Oceania intranet. This surveillance data is reviewed by the Oceania clinical quality team and reported to the Oceania board on a monthly basis.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short-term care plans and in progress notes.</p>

		<p>This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interviews, the ICN and CM confirmed that no outbreaks occurred at the facility since last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. The restraint minimisation policies and procedures identify that restraint is only to be put in place where it is clinically indicated and justified and approval processes are obtained/met. Policies and procedures include definition of restraint and enabler that are congruent with the definition in the standards.</p> <p>There were no residents with restraints or enablers at the facility on audit days.</p> <p>Staff interviews and staff records evidence training and education has been provided on restraint minimisation and safe practice, enabler usage and prevention and/or de-escalation techniques. The CM is the designated restraint coordinator.</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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>The interRAI assessments were current for all the residents' files reviewed, however, in 5 of 8 files reviewed initial interRAI assessments were not completed within the required 21 days of the resident's admission to the facility.</p> <p>The long-term care plans were current and reviewed six monthly. The review of residents' files evidenced 8 of 4 long-term care plans were not completed within the 21 day timeframe following admission.</p> <p>The initial medical examination of a resident occurs within two to five working days of admission by the GP. Four of eight residents' files evidenced the residents were not always examined monthly and resident's medical condition was not assessed as stable by the GP for the medical examinations to occur three monthly.</p> <p>The residents' with dementia have a challenging behavioural assessment and care plan documented and reviewed six monthly or more frequently when this is required. All residents in the dementia unit had a documented 24 hour activities care plan with activities that meet the resident's needs in relation to managing behaviours that challenge. The</p>	<p>i) The initial interRAI assessments are not always completed within the required 21 days of residents' admission to the facility.</p> <p>ii) The long-term care plans are not always completed within the required 21 days of residents' admission to the facility.</p> <p>iii) The GP</p>	<p>Provide evidence the initial interRAI assessments, long-term care plans, medical reviews and 24 hour activities care plans are conducted and reviewed according the required timeframes.</p> <p>90 days</p>

		<p>tracer methodology file of a resident in the dementia unit evidenced the 24 hour activities care plan was not being reviewed every six months. Review of all residents' files in the dementia unit evidenced 7 of the 11 residents' files did not have 24 hour activities care plans reviewed six monthly.</p>	<p>exception for residents to be examined less frequently than monthly is not consistently documented and the medical reviews are not always completed monthly as required.</p> <p>iv) The 24 hours activities care plans for residents' with dementia are not always reviewed six monthly.</p>	
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.