

Oceania Care Company Limited - Greenvalley

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: Greenvalley

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 21 May 2019 End date: 22 May 2019

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: 45

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Greenvalley (Oceania Healthcare Limited) can provide care for up to 50 residents requiring rest home and dementia level of care. There were 45 residents at that facility on the first day of the audit.

This surveillance audit was completed against the relevant Health and Disability Service Standards and the contract with the district health board.

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

The previous requirement for improvement relating to risk assessments being completed within the required timeframes has been closed out. There are no requirements for improvement from this surveillance audit.

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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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 information is provided to residents on admission and available in the facility.

There is a documented complaints management system and a complaints register is maintained. The business care manager is responsible for managing complaints. All complaints are investigated and documented, with corrective actions implemented. There have been no complaints to external agencies since the last audit.

Staff communicate with residents and family members following any incident and this is recorded in the residents' files.

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 responsible for the services provided at Greenvally.

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement. Monthly reports to the national support office include monitoring of service delivery.

Quality and risk performance is monitored through the organisation's reporting systems. Benchmarking reports include, but are not limited to, falls, infections, restraint, health and safety and complaints.

An internal audit programme is implemented. Corrective action plans were in place where required and included evidence of the resolution of issues. There is an electronic database to record risk in which risks and controls are clearly documented. The service has implemented an electronic system for the management of clinical care.

The facility is managed by an appropriately qualified and experienced business and care manager and supported by a clinical manager who is responsible for the oversight of clinical service provision. The clinical manager is a registered nurse. The facility management team is supported by the regional clinical quality manager and the regional operations manager.

Oceania Healthcare Limited human resource policies and procedures are implemented, and newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff who require them are validated annually. An annual training plan is implemented to ensure ongoing training and education, including dementia training for all staff members.

A review of rosters and service delivery staff, and resident/family interviews confirmed there is adequate staff available.

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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Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after admission.

The interRAI assessment process is used to identify residents' needs and are completed within the required timeframes. The contracted general practitioner completes a medical assessment on admission and reviews occur thereafter on a regular basis.

Electronic resident long-term care plans are developed and implemented. Care plans are individualised and based on an integrated range of clinical information. Short-term care plans are in place to manage short-term issues or problems as they arise. Residents' files reviewed demonstrated their needs, goals and outcomes are identified and reviewed. Interviews confirmed residents and their families are informed and involved in the care planning and evaluation of care. Handovers between shifts guide continuity of care and team work is encouraged.

The activity programme is managed by a diversional therapist and an activities assistant. The programme provides residents with a variety of individual and group activities. Activities are provided over the 24-hour period for the residents in the dementia service. The service uses its facility van for outings in the community. Family are able to participate in the activities programme.

Medicine management occurs according to policies and procedures and in alignment with legislative requirements and is implemented using an electronic system. Medications are administered by registered nurses and senior health care assistants. Medicine management competencies reviewed for staff who administer medicines were current.

The food service meets the nutritional needs of the residents. Kitchen staff have food safety qualifications. The kitchen was clean and meets food safety standards. The food service has a food control plan that is current and displayed. Residents and family confirmed satisfaction with meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness. There have not been any 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.
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The organisation implements policies and procedures that support the minimisation of restraint. There were no enablers or restraint in use at the time of audit. Staff interviews confirmed understanding of the restraint and enabler processes. When enablers are used, enabler use is voluntary. Restraint education is provided to staff at orientation and annually thereafter. A restraint register is maintained.

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 surveillance is undertaken, analysed and trended. Results are reported to staff. Surveillance records showed evidence of follow-up of infection when required. The infection surveillance programme is reviewed annually. Staff interviewed demonstrated current knowledge and practice of infection control principles.

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	18	0	0	0	0	0
Criteria	0	40	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The business and care manager (BCM) is responsible for managing complaints. An up-to-date complaints register is in place and includes the date the complaint is received; a description of the complaint; the investigation undertaken; resolution and the date the complaint is signed off. Evidence relating to each lodged complaint is held in the complaints register. The complaints reviewed indicated that complaints are investigated, and issues are resolved in a timely manner.</p> <p>Staff and resident interviews confirmed that residents and families are encouraged to raise any concerns and provide feedback on services. Residents' meeting minutes confirmed that the complaints process is re-iterated at the meetings. Residents and family interviews stated they were aware of a complaints process and that they could make a complaint. Residents and family interviews confirmed an understanding of their rights to advocacy and how to access advocacy services particularly in relation to the complaints process. There have been no complaints referred to external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>The open disclosure policy ensures there is open discussion of any adverse event where a resident experienced unintended harm whilst receiving care. Completed incident forms and residents' records demonstrated that family are informed of incident/accidents. Family and resident interviews confirmed they are informed of changes in resident status and they attend care planning meetings</p>

<p>provide an environment conducive to effective communication.</p>		<p>for the resident.</p> <p>Monthly resident meetings inform residents of facility activities and provide an opportunity to: make suggestions; provide feedback; and to raise and discuss issues/concerns with management.</p> <p>Minutes of the residents' meetings sighted evidenced that a range of subjects are discussed. Residents and family have access to the minutes from these meetings and minutes are available in large print. Residents and family are also provided with copies of upcoming planned activities and menu.</p> <p>Residents who do not speak English as their first language are offered interpreting services. The facility has processes in place to facilitate effective communication with residents who do not have the ability to verbally communicate.</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>Oceania Healthcare Limited (Oceania) has a documented vision, mission and values statement which reflects a person-centred approach to all residents. These values are communicated to residents, families and staff through the internet and information provided to new residents and families on admission. Staff receive this information in annual training. In addition to the overarching Oceania business plan, the facility has specific business planning objectives that are included within their annual budget specific to Greenvalley.</p> <p>The facility is part of the Oceania group with the executive management team providing support. Communication between the facility and executive management occurs monthly with the clinical and quality and operations managers providing support during the audit. Monthly reports from the facility provides the executive management team with progress against key quality indicators.</p> <p>The BCM is supported by a clinical manager (CM). The BCM has been in the role for one year and has completed the Oceania managers training. The BCM previously worked as the CM and has been with Oceania for three years.</p> <p>The CM has been working in the facility as a registered nurse (RN) for two years and has been in the CM role for one year. The CM holds a current annual practising certificate and is supported by the Oceania clinical and quality manager (CQM). The management team have completed appropriate induction and orientation to their roles.</p> <p>Greenvalley can provide services for up to 50 residents. The facility is certified to provide rest home and dementia care services with 45 beds occupied at the time of the audit. There are 30 rest home beds of which 28 were occupied and 17 of 20 beds in the dementia unit were occupied. The facility does not have any occupational right agreements. The service has a contract with the district health board for rest home level respite care. There were no residents under this contract at the time of</p>

		audit.
<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>The facility utilises Oceania’s documented quality and risk management framework that is available to staff to guide service delivery. Policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies are presented to staff at staff meetings and policy updates are also provided as part of relevant in-service education. New and revised policies are also made available on a notice board in the staff room and staff sign to confirm that that they have read and understood each new policy and/or update. Staff interviews confirmed that they are made aware of new and updated policies.</p> <p>Service delivery is monitored through the organisation’s reporting systems utilising several clinical indicators such as complaints; falls; infections; wounds; urinary tract infections; incidents and accidents; medication errors and implementation of the internal audit programme. There was evidence that the internal audit programme is implemented as scheduled. Reports evidence that quality improvement data is being collected and collated with the identification of trends and analysis of data. Where required, corrective action plans are developed, implemented, evaluated and closed out. There is communication with all staff of any subsequent changes to procedures and practice through meetings and staff notices.</p> <p>Residents and families are notified of updates through the facility’s residents’ meetings. Residents’ meeting minutes confirmed that families of residents from the dementia unit have opportunity to contribute to quality improvements and facility equipment. Interviews with families of residents in the dementia unit are satisfied that services meet their individual needs and that they have input into services.</p> <p>Quality and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. Staff reported that they are kept informed of quality improvements. Copies of meeting minutes are available for review in the staff room and staff sign to confirm that they have read and understood these. Staff interviews and meeting attendance records confirmed that attendance at staff meetings is encouraged and facilitated.</p> <p>Satisfaction surveys for residents and family are completed as part of the internal audit programme and these evidenced satisfaction with services provided. This was confirmed by resident and family interviews.</p>
<p>Standard 1.2.4: Adverse Event</p>	FA	<p>The BCM is aware of situations which require the facility to report and notify statutory authorities,</p>

<p>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>including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. These are reported to the appropriate authority via Oceania support office staff. There was evidence HealthCERT had been notified of the changes in management. Interviews confirmed that there had been no events that required reporting since the last audit. There has been one investigation referred to the coroner and this remains open.</p> <p>Staff interviews, and review of documentation confirmed that staff document adverse, unplanned or untoward events on an accident/incident form which are signed off by the BCM.</p> <p>Staff interviews confirmed that they are encouraged to recognise and report errors or mistakes. Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. Staff records reviewed demonstrated that staff receive orientation and education on the incident/accident reporting process.</p> <p>Incident/accident reporting forms are readily available. Incident/accident reports selected for review evidenced that the resident's family had been notified, an assessment had been conducted and observations completed. Corrective actions arising from incidents/accidents were implemented. There is evidence of a corresponding note in the resident progress notes and notification of the resident's family member where appropriate.</p> <p>Accident/incidents are graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Accident/incidents are also discussed at quarterly regional cluster meetings. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared at monthly staff meetings.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The facility's staffing rationale informs recruitment processes to ensure that suitable staff are appointed and available to meet the needs of all residents including those with dementia. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; identification verification; a position specific job description; and a signed employment agreement.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that require them including: RNs, the pharmacists, general practitioner (GP), dietitian and podiatrist.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on several tasks, including</p>

		<p>personal cares.</p> <p>The organisation has a documented role specific mandatory annual education and training module/schedule. There are systems and processes in place to ensure that all staff complete their required mandatory training modules and competencies.</p> <p>The BCM, CM and two other RNs have completed interRAI assessment training and competencies. Care staff complete annual competencies, for example: moving and handling; hoist use; hand washing; and infection control. Education session attendance records evidenced that ongoing education is provided relevant to the services delivered including dementia level of care. Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of relevant education and training hours per annum. An appraisal schedule is in place and all staff files reviewed for staff employed greater than one year, evidenced a current performance appraisal.</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 facility currently has 42 staff consisting of the management team; RNs; health care assistants (HCA); a diversional therapist; an activities assistant; and household staff. Household staff include kitchen and housekeeping staff who provide services seven days a week.</p> <p>The organisation's staffing and skill mix policy and formula provide guidance to ensure safe staffing levels within the facility meet the needs of residents' acuity and the minimum requirements of the DHB contract. Rosters are formulated two weeks in advance and staffing levels are reviewed to accommodate anticipated workloads, identified numbers, and appropriate skill mix, or as required due to changes in the services provided and the number of residents.</p> <p>There are RNs and HCAs available to safely maintain the rosters for the provision of care. There is a pool of casual RNs and HCAs available to supplement rosters when needed to accommodate increases in workloads and the acuity of residents. Rosters sighted reflected staffing levels meeting current resident acuity and bed occupancy.</p> <p>The BCM and CM are on call after hours, seven days a week.</p> <p>Observation of service delivery confirmed that resident needs were being met in a timely manner. Residents and family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed that they have time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable,</p>	<p>FA</p>	<p>.</p>

<p>timely, and respectful manner, when their need for services has been identified.</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 system is documented and implemented and complies with legislation, protocol and guidelines.</p> <p>The service uses pharmacy pre-packaged medicine that is checked by the RN on delivery. An electronic medication system is used. Weekly checks and six monthly stocktakes of medicines are conducted and confirmed that stock matched expected levels. Pharmacy input was verified.</p> <p>The medication refrigerator temperatures are monitored. A system is in place for returning expired or unwanted medication to the contracted pharmacy. All medications are stored appropriately. Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN and the CM confirmed this.</p> <p>The staff administering medication complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled where applicable. The RNs oversee the use of all pro re nata (PRN) medicines and comments made regarding effectiveness on the electronic medication record sighted. Observation of the lunchtime administration evidenced this was in line with legislation, protocols and guidelines.</p> <p>There is one resident in the rest home self-administering medication during the on-site audit days. A process is in place to ensure ongoing competency of the resident and this is authorised by the GP. Medication is blister packed and stored safely.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals are prepared on site and served in two different dining rooms. The seasonal menu has been reviewed by a dietitian, with the winter menu implemented at the time of audit. The food control plan's expiry date is 21 September 2020. Current food management training and certificates for cooks and kitchen staff were sighted.</p> <p>Residents' dietary profiles are developed on admission and identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff on a resident's admission to the facility, when a resident's dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs of residents. Supplements are provided to residents with identified weight loss problems as medically required.</p> <p>All food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit meets the requirements of the standard. The cook is responsible for purchasing the food to</p>

		meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and cool store which are daily temperature monitored. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The residents' care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. Care planning includes specific interventions for long-term and acute problems. Interventions are reviewed within required timeframes and updated if there are changes in the health status of a resident. The GP documentation and records reviewed were current. Interviews with residents and families confirmed that care and treatment met residents' needs. Staff interviews confirmed they are familiar with the needs of all residents in the rest home and the dementia service. Family communication is recorded in the residents' files. The nursing progress notes and observations are recorded electronically and maintained.</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 residents' activities programme is developed by the diversional therapist and activities assistant. The activities for the residents are provided seven days a week. The diversional therapist oversees the programme for both the rest home and dementia services and is responsible for the implementation of the activities sessions in the dementia care unit. The activities assistant is responsible for the implementation of the programme in the rest home. Two students provide activities in the weekend. The activities programme was displayed and implemented in both service areas. A range of activities are planned which incorporate education, leisure, cultural and community events. Van outings into the community are arranged twice a week.</p> <p>The residents' activities assessments are completed within three weeks of the residents' admission to the facility. Information on residents' interests, family and previous occupations are gathered during the interview with the resident and their family.</p> <p>There is a 24-hour activity plan for the dementia level care residents with times of day when additional activities are required. Strategies are documented for managing individual residents with challenging behaviour and for providing activities of interest to the individual's well-being.</p> <p>The activities plans are reviewed six-monthly at the same time the care plans are reviewed.</p> <p>There was evidence the activities staff are part of the interRAI and care plan review process. The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging in a variety of activities in both the rest home and the dementia unit.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>The long-term care plans are evaluated every six months in conjunction with the interRAI re-assessments or as the residents needs change. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. Residents and families interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident's records and documented on the family communication record in the individual resident files reviewed.</p> <p>Short-term care plans are developed for acute problems when needed and record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved.</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 in the entrance to the facility. There have been no building alterations to the facility since the last audit.</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>The infection prevention and control programme is site specific and reviewed annually. The surveillance policy identifies the requirements around the surveillance of infections. The infection logs are maintained and collated monthly by the CM. The CM is also the infection prevention and control nurse.</p> <p>Residents' files reviewed electronically evidenced that those residents with an infection had a short-term care plan in place. The GP interviewed confirmed infections are reported in a timely manner.</p> <p>In interviews care staff reported they are made aware of any infections through feedback from the RNs or the CM, verbal handovers, short-term care plans and the progress notes. This was confirmed during attendance at the handover and review of the residents' files randomly selected. The CM confirmed that there had been no outbreaks of infection at the facility since the previous audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The Greenvalley restraint minimisation and safe practice policies and procedures comply with legislative requirements.</p> <p>The restraint coordinator is the CM. A signed position description was sighted. The restraint register is maintained. There were no residents using restraints or enablers at the time of the on-site audit. Interviews with staff confirmed enabler use is voluntary. Restraint minimisation and safe practice education is provided to all staff at orientation/induction to the service and ongoing education is provided to staff annually.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	

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.

No data to display

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.