Oceania Care Company Limited - Wesley Village

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:	Wesley Rest Home
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: 4 July 2019 End date: 5 July 2019

Proposed changes to current services (if any): Providing services for residents receiving residential disability services.

Total beds occupied across all premises included in the audit on the first day of the audit: 60

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

Wesley Village (Oceania Healthcare Limited) can provide care for up to 71 residents requiring rest home or hospital level of care. The facility is certified to provide hospital, rest home and dementia level care. There were 60 residents at that facility on the first day of the audit.

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

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

Areas requiring improvement at the last audit relating to communication, complaints and the laundry service have been closed out.

There were no areas identified as requiring improvement at 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.

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 provided to residents on admission and available within the facility.

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

Residents, family and nurse practitioner interviews confirmed that the environment is conducive to communication, including identification of any issues, and that staff are respectful of residents' needs.

There is a documented complaints management system and a complaints register is maintained. The business care manager is responsible for managing complaints. Complaints are investigated and documented, with corrective actions implemented where required. There has been one complaint to an external agency since the last audit which has been resolved.

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.

Oceania Healthcare Limited is the governing body responsible for the services provided at Wesley Village.

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement at the facility. Policies are reviewed. Reports to the national support office allow for the monthly 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 are documented with evidence of resolution of issues when these are identified. There is an electronic database to record risk in which risks and controls are clearly documented.

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. Both the business and care manager and the clinical manager are registered nurses. 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. Newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff and contractors who require them are validated annually. An annual training plan is implemented to ensure ongoing training and education for all staff members.

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

Registered nurses complete resident assessments on admission to the service. InterRAI assessments were current and completed within the required timeframes.

Person centred care plans are individualised and based on a comprehensive and integrated range of clinical information. Short-term care plans are in place to manage short-term problems. Residents' records reviewed demonstrated their needs, goals and outcomes are identified and reviewed at regular intervals. Interviews confirmed residents and their families are informed and involved in care planning and evaluation of care. Handovers guide continuity of care. The service uses an electronic system for the management of clinical services.

The activity programme is managed by the diversional therapist. The programme provides residents with a variety of individual and group activities, including additional activities for younger people with disabilities and sensory specific activities for residents in the dementia unit. The service uses its facility bus for outings in the community.

Medicines management occurs according to policies and procedures, in alignment with legislative requirements and consistently implemented using an electronic system. Medicines management competencies for staff who administer medicines were current.

The facilities food service meets the nutritional and other specific needs of the residents. Staff working in the kitchen have food safety qualifications. The kitchen was clean and met food safety standards. Residents confirmed 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.

A current building warrant of fitness is displayed. There had 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.

The organisation implemented policies and procedures that support the minimisation of restraint. There were no enablers and three restraints, in the form of bedrails, in use at the time of audit.

Restraint is only used as a last resort when all other options have been explored. Enabler use is voluntary, when used. Staff interviews confirmed understanding of restraint and enabler processes.

Infection prevention and control

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

Infection surveillance is undertaken, analysed, trended and benchmarked. Results are reported to the Oceania Healthcare Limited national support office.

Surveillance records showed evidence of the follow-up of infections, when required. Staff demonstrated current knowledge and practice in relation to the implementation of infection prevention and control. The infection prevention and control programme is reviewed annually. There have been no outbreaks since the last audit.

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	17	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The BCM is responsible for managing complaints. An up-to-date complaints register is in place that 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 folder and on the complaint register. The complaints reviewed indicated that complaints are investigated promptly, and issues are resolved in a timely manner. Business and care manager and resident interviews confirmed that residents and family were aware of opportunities and processes to raise any concerns and provide feedback on services. Residents' meeting minutes confirmed that the complaints process is re-iterated at their meetings. Residents and family interviews confirmed that they were aware they could make a complaint and stated that they felt comfortable raising concerns directly with staff if they needed to. They stated that any issues raised had been dealt with to their satisfaction. The previous requirement for improvement relating to complaint follow up and feedback to complainant has been implemented. 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. A local chaplain is available to provide advocacy services and visits the facility weekly to meet with residents on a one-to-one. The chaplain is the independent chair at resident meetings. There have been no complaints lodged with the Health and Disability Commissioner since the previous audit. One complaint laid with the district health board (DHB) via the Ministry of Health, relating to a resident absconding from

		the facility. In response the facility has initiated a reassessment of the resident concerned and they have been reassessed as requiring secure dementia level of care. The facility had also agreed with the resident's family to an increase in personal companion hours; and appointed additional health care assistant (HCA) full time equivalent. The complaint has been closed by the DHB.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy that sets out the process to guide staff and ensures there is open disclosure of any adverse event where a resident has suffered any unintended harm while receiving care. Completed incident forms and residents' records reviewed demonstrated that family are informed if the resident has an incident/accident; a change in health or a change in needs. Family and resident interviews, including younger people with a disability (YPD) interviews by the consumer auditor, confirmed that family are informed of any changes in resident status and that they are invited to the care planning meetings for the resident. Two monthly resident meetings inform residents of facility events and activities and provide attendees with an opportunity to: make suggestions; provide feedback; and to raise and discuss issues/concerns with management. Upcoming resident meetings are included in the weekly activities planner and advertised on the resident notice board. Family are invited by email or in person to attend the meetings. Minutes from the residents' meetings showed evidence that a range of subjects are discussed, including food services; the proposed new kitchen; staff changes; the complaints and feedback processes; chaplain services and activities. Residents and family are provided with copies of meeting minutes by the diversional therapist. Residents and family are also provided with copies of upcoming planned activities and the four weekly meal planners are displayed on the notice board in the dining room. Resident and family stated that they felt comfortable approaching the business and care manager (BCM) and clinical manager (CM) who they described as being approachable and responding promptly to any issues/concerns raised. The previous requirement for improvement relating to communication with families/representatives has been implemented. There is policy that provides guidance and procedures for staff to ensure that residents who do not use English as their first language are offered interpreting services. It states that staff have access to a list of interpreting services and family may only interpret with a resident's consent. Staff represent a number of ethnicities and are fluent in Pilipino, Chinese, Mandarin, Cantonese, Fijian, Samoan, and Tongan. These staff are able to assist with interpreter services in their native languages if required. At the time of the audit there were five residents for whom English was not their first language and staff, as well as family members, were able to assist with interpretation when required, if the resident requested. Interpreter services can also be accessed through Language Line if needed.
Standard 1.2.1: Governance	FA	Oceania Healthcare Limited (Oceania) has a documented vision, mission and values statement which reflects a person-centred approach to all residents, including YPD. The organisation's values are displayed in entrance to the facility for residents and visitors. Staff also receive this information at orientation and in annual training. Oceania has

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		an overarching business plan and the facility has specific business planning objectives that are reflected in an annual budget specific to Wesley Village. Wesley Village is part of the Oceania group with the executive management team providing support to Wesley Village. Communication between the facility and executive management occurs at least weekly with the regional clinical and quality manager (CQM) providing support during the audit. The facility provides ongoing electronic reporting of events and occupancy that provide the executive management team with progress against identified indicators. The BCM has been in the role for 18 months and has previous experience as a registered nurse (RN), CM and manager at other aged residential care facilities. The BCM is a RN with a current practising certificate. The BCM is supported by a CM. The CM has been in the role for over one year and has three years previous experience in CM roles in other age care facilities. The CM holds a current annual practising certificate and is supported by the Oceania CQM. The management team have completed appropriate induction and orientation to their roles. Wesley Village can provide services for up to 71 residents. The facility is certified to provide rest home and hospital care services, with 60 beds occupied at the time of the audit. Occupancy included: 13 residents requiring rest home level care; 26 requiring hospital level care and 14 assessed as requiring dementia level care. In addition, there were seven residents classified under the long-term support - chronic health conditions contract who were under 65 years of age. The seven YPD residents had been assessed as having a physical/sensory disability requiring hospital level of care. The facility holds a contract with the DHB for long-term chronic conditions. The facility does not have any occupational right agreements.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	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 located in the staff room and staff sign to confirm 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. Service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators such as: absconders, complaints; falls; infections; medication errors; restraint; sentinel events; urinary tract infections; incidents and accidents; and implementation of the internal audit programme. Clinical indicators are collated monthly. There is evidence that the annual internal audit programme is implemented as scheduled. Reports show 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.

		Residents and family are notified of updates to relevant policies, processes and events through the facility's two monthly residents' meetings and emails. Residents' meeting minutes, staff and YPD resident interviews confirmed that residents, including YPD, have the opportunity to have input into quality improvements, room choices and facility equipment. Interviews confirmed that residents, including YPD, are satisfied the services meet their individual needs and that they have input into services. Monthly quality, health and safety and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. Staff interviews 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 was facilitated. Satisfaction surveys for residents and family are completed six-monthly as part of the internal audit programme. Surveys reviewed evidenced satisfaction with the services provided. This was confirmed by resident and family interviews. The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes. The need to report hazards, accidents and incidents promptly is reiterated at health and safety and quality meetings. A RN is the nominated health and safety representative. Interview confirmed a clear understanding of the obligations of the role. The interview with the BCM and health and safety representative confirmed that the facility was proactive in encouraging hazard identification and reporting. Where an opportunity to improve hazard reporting by staff had been identified, an incentive programme had been introduced, with a subsequent improvement in hazard identification. There is evidence of hazard identification forms completed when a hazard is identified and that hazards are addressed, and risks minimised. A current hazard register is available that is reviewed and updated annually or when a new hazard is identified.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected	FA	The BCM is aware of situations which require the facility to report and notify statutory authorities, 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. Interviews and documentation reviewed confirmed that there had been two events relating to residents absconding that required reporting since the last audit. Business and care manager interview confirmed that the appointment of the BCM and CM since the last audit had been reported to the Ministry of Health. Staff interviews and review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the BCM. Staff training records reviewed confirmed that staff receive education at orientation and as part of the ongoing

consumers and where appropriate their family/whānau of choice in an open manner.		training programme on incident and accident reporting processes. Staff interviews confirmed that they are made aware of the importance of identifying and reporting errors or mistakes. Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. Accident/incident reporting forms are readily available. Accident/incident reports selected for review evidenced that where appropriate the resident's family had been notified, an assessment had been conducted and observations completed. Corrective actions arising from accidents/incidents were implemented. There is evidence of a corresponding note in the resident progress notes and notification of the resident's family member where appropriate. Family and resident interviews confirmed that family are notified where the resident has had an accident or a change in health status. Accident/incidents are graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared at monthly staff meetings.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resource management policies and procedures are implemented and meet the requirements of legislation. 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. 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 and contractors that required them. An orientation/induction programme is available that covers the essential components of the services provided. Health care assistants are paired with a senior HCA for nine shifts or until they demonstrate competency on a number of tasks, for example: hand hygiene; medication and moving and handling. Health care assistants confirmed their role in supporting and buddying new staff. 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. The BCM, CM and three other RNs have completed interRAI assessments training and competencies. Care staff complete annual competencies, for example: moving and handling; hoist use; hand washing; wound management; medication management; restraint: blood sugar and insulin. Education session attendance records evidenced that ongoing education is provided relevant to the services delivered including services for YPD residents. Of the six HCA working in the dementia unit at the time of audit, three had completed dementia unit standards to level three

		and three had completed level four. 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 that includes an initial appraisal three months after commencement and annually thereafter. Staff files reviewed evidenced a current performance appraisal.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The facility currently has 55 staff consisting of: a management team; RNs; HCAs; diversional therapist (DT), maintenance personnel and household staff. Household staff include: kitchen and housekeeping staff who provide services seven days a week. The organisation's staffing and skill mix policy and formula provide guidance to ensure safe staffing levels within the facility are sufficient to 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. There are sufficient 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 such as additional hospital level residents. Additional staff may be sourced from time to time through a nursing bureau. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy and demonstrated that there is at least one RN on each shift. The BCM and CM share the on call after hours, seven days a week. 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 sufficient time to complete their scheduled tasks and resident cares.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	FA	The medicine management system is documented and implemented and complies with legislation, protocols and guidelines. The service uses pharmacy pre-packaged medicine that is checked by the RN on delivery. A computer-based medication system is used. Weekly checks and six-monthly stocktakes are completed and confirmed that stock levels were correct. The medication refrigerator temperatures are monitored. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are stored appropriately. The staff administering medication were observed to be complying with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled. There was one resident in the rest home self-administering medications on audit days. All checks and reviews are completed for this resident to ensure they are competent to self-administer medicines. Policies and procedures are

guidelines.		in place to ensure safe storage and alignment with policy in relation to self-administration of medications. Young people with disabilities who are competent to make their own decisions have the choice to self-administer medicines. None of the YPDs were self-administering medicines on the days of audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan. Meals are prepared at another Oceania site, transported and served in the dining areas at Wesley. The menu used follows summer and winter patterns and has recently been reviewed by a dietitian. The meals are delivered by van twice a day before lunchtime and before the evening meal. Breakfast is provided on-site by staff. In the dementia unit the food is delivered in a trolley at each mealtime. Residents have access to food and fluids, meeting their nutritional needs at all times. Wesley employs kitchen assistants who are responsible for the temperature monitoring, food service and cleaning after each mealtime. The chef had completed safe food handling qualifications and the other kitchen staff had current food management certificates. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to the chef at the other Oceania site who ensures the individual needs of the residents are met. Supplements are provided to residents with identified weight loss problems.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The residents' care plans are completed by the RN and based on assessed needs, including the interRAI assessment, desired outcomes and goals of the residents. Care planning includes specific interventions for both long-term and short-term problems. The nursing progress notes, observation charts and other clinical interventions are maintained electronically. The GP/NP documentation and records reviewed were current. Interviews with residents and families confirmed that care and treatment meets residents' needs. Staff interviews confirmed they are familiar with the needs of the residents in all areas of care, including hospital level of care for older people and YPD, rest home care and the dementia level of care. Family communication is recorded in the residents' files.
Standard 1.3.7: Planned Activities Where specified as part of the service	FA	The residents' activities programme is developed and reviewed by the DT. The activity programmes are implemented. There are specific activity programmes focusing on the specific needs of the different levels of care. The residents' activities assessments are completed within the three weeks of their admission to the facility. Information on residents' interests are gathered during an interview with the resident and their family. The activity

delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		care plan is part of the long-term care plan and reflects the residents' preferred activities. There was evidence the activities staff participate in the care planning process. Residents in dementia care have additional activities to help manage behaviour 24 hours day. The residents in the dementia unit have challenging behaviour management plans on file. Activities for YPDs include a range of activities specific to each individuals' needs and interests, including; recreation, leisure, cultural and community involvement. 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 and outings.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long-term and the short-term care plans are evaluated in a timely manner. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Residents' responses to the treatment regime are documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. Young People with disabilities evaluate their personal goals with the assistance from staff. Short-term care plans are developed 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.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness. There had not been any alterations to the building since the last audit.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe	FA	Laundry is undertaken off site, with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry, with separate access to take clean and dirty laundry in and out. Observation, patient and staff interviews confirmed that the laundry is managed to a high standard and there is sufficient stock available to meet facility needs. Resident personal clothing is also laundered of site and there are systems in place to ensure that resident personal items are laundered appropriately and returned to the resident in a timely manner. These include, labelling of personal clothing, checking the inventory of personal clothing on return to the facility,

and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		regular internal auditing and prompt follow-up of missing items. There are cleaners on site during the day, seven days a week. The cleaner has a trolley to put chemicals in and they keep the trolley with them, or in sight, always. All chemicals are in correctly labelled containers. Cleaning chemicals have medical safety data sheet (MSDS) located in relevant areas. There are guidelines and instruction available and ongoing training around use of products and new procedures and products provided. Cleaning and laundry management is routinely monitored monthly through the internal audit process with no issues identified. The previous requirement for improvement regarding personal laundry has been closed.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy identifies the requirements around the surveillance of infections. The infection logs are maintained and collated monthly by the infection control nurse (ICN) who is a registered nurse. The ICN has a signed job description in place. Collated data are communicated as clinical indicators to the Oceania support office and to management and staff. Residents' files evidenced that those residents diagnosed with an infection had short-term care plans in place. The NP interview confirmed infections are reported in a timely manner. In interviews, staff reported they are made aware of any infections through feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was confirmed during attendance at the handover and review of the residents' files. The CM confirmed that there had been no outbreaks of infection at the facility since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The Oceania restraint minimisation and safe practice handbook and policies comply with legislative requirements. The restraint coordinator is one of the RNs. A signed position description was sighted. Restraints are minimised by using challenging behaviour management plans and other interventions to prevent the use of restraint. Where possible, high/low beds are in place and for residents who are at risk of falling. There are also sensor mats in place where required to alert staff when a resident with a falls risk mobilises without assistance. There were three restraints and no enablers being used at the time of the audit. The only form of restraint at the time of the audit was bedrails. A restraint register is maintained and was current. Required documentation relating to restraint is recorded. Staff receive restraint education via the Oceania study days and RN study days.

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, these 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.