

# Oceania Care Company Limited - Whareama Rest Home & Hospital

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## 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:** Whareama Rest Home

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 July 2019 End date: 24 July 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:** 56

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
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

Whareama Rest Home & Hospital (Oceania Healthcare Limited) can provide care for up to 81 residents requiring rest home or hospital level of care. There were 56 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 general practitioner.

There were no areas requiring improvement at the last certification audit.

There was an area identified as requiring improvement at this surveillance audit relating to care planning interventions.

## 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.

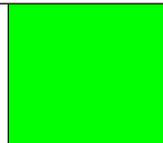
Staff communicate with residents and family members following any incident as recorded in the residents' files.

Residents, family and general 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 and care manager is responsible for managing complaints. Complaints are investigated and documented, with corrective actions implemented where required. There have been no complaints to external agencies since the last audit.

## 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 Whareama Rest Home & Hospital.

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 the 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, 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 sufficient 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.		Some standards applicable to this service partially attained and of low risk.
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Registered nurses assess residents on admission within the required timeframes. The initial care plan guides care and service provision during the first three weeks after admission.

The interRAI assessment is used to identify residents' needs. The resident's general practitioner or nurse practitioner complete a medical assessment on admission and reviews occur thereafter on a regular basis.

Person centred care plans are developed and implemented, these are individualised and based on a comprehensive and integrated range of clinical information. Short-term care plans are in place to manage any new issues. 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. Shift handovers guide continuity of care and team work is encouraged.

The planned activity programme is managed by two qualified diversional therapists. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is used 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. Medication management is consistently implemented using an electronic system. Medications are administered by registered nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special requirements catered for. Kitchen staff complete food safety qualifications. The kitchen was organised, clean and meets food safety standards. A current food control plan is displayed and guides food service delivery. Residents and family interviewed 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.
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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.
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The organisation implements policies and procedures that support the minimisation of restraint. One enabler and three restraints were in use at the time of audit. Staff receive training at orientation and annually on all aspects of restraint and enabler use, alternatives to restraint and managing challenging behaviours. Interviews confirmed understanding of the restraint and enabler processes. When enablers are used, enabler use is voluntary. 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.

Infection prevention and control surveillance is undertaken, analysed and trended. Results are reported to staff. Records showed follow-up action is taken as and when required. The infection control programme is reviewed annually. Staff interviewed demonstrated current knowledge and practice of infection control principles. Regular education in infection control is provided to all staff.

## 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)
<b>Standards</b>	0	16	0	1	0	0	0
<b>Criteria</b>	0	38	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 BCM is responsible for managing complaints. An up-to-date complaints register is in place that includes: the date the complaint is received; the category and a summary of the complaint; how the complainant was contacted; if the complaint was reviewed/audited; and the date the complaint was closed/resolved. Evidence relating to each lodged complaint is held in the complaints folder with the register. The complaints reviewed indicated that complaints are investigated promptly, and issues are resolved in a timely manner.</p> <p>Resident interviews confirmed that they were aware of opportunities and processes to raise any concerns and provide feedback on services. Staff and resident interviews and residents' meeting minutes confirmed that residents can raise and discuss concerns and provide feedback on services at resident meetings. Residents and family interviews confirmed that they were aware they could make a complaint. They stated that they were satisfied with how any issues raised had been dealt with.</p> <p>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.</p> <p>There have been no complaints lodged with external agencies since the previous audit.</p>
Standard 1.1.9:	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 unintended harm while receiving care. Completed incident forms

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>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 confirmed that family are informed of any changes in resident status and that they are invited to the care planning meetings for the resident.</p> <p>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 or concerns with management. Upcoming resident meetings are included in the activities planner and advertised on the resident notice board as sighted during on-site audit. Family are welcome to attend the meetings. Minutes from the residents' meetings showed evidence that a range of subjects are discussed, including the: facility; laundry; meal service; pets; and activities.</p> <p>Resident and family stated that they felt comfortable approaching the business and care manager (BCM) and clinical manager (CM) and that issues/concerns raised are responded to efficiently.</p> <p>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. Interviews confirmed that in the advent that interpreter service were required these would be accessed through the local advocacy service or district health board (DHB). At the time of the audit there were no residents for whom English was not their first language.</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 mission, vision and values statements which reflect a person-centred approach to all residents. These are described in the information pack provided to residents and their families on admission and displayed in entrance to the facility for residents and visitors. Staff also receive this information at orientation and in annual training. Oceania has an overarching business plan applicable to this facility.</p> <p>Whareama Rest Home &amp; Hospital is part of the Oceania group with the executive management team providing support to Whareama Rest Home &amp; Hospital. Communication between the facility and executive management occurs at least monthly 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.</p> <p>The BCM, who was on leave at the time of the audit, has the dual responsibility for this and another aged care facility that is situated within walking distance from Whareama Rest Home &amp; Hospital. The BCM has been in this role for 2 years. The BCM has 3 years previous experience managing another Oceania facility. Prior to this the BCM worked for Oceania as a temporary BCM at other aged residential care facilities. The BCM is a registered nurse (RN) with a current practising certificate. The BCM is supported by a clinical manager (CM). The CM has been in the role for just over 18 months and has 3 years previous experience as a RN at aged care facilities, including experience working in dementia care. The CM holds a current annual practising certificate and is</p>

		<p>supported by the Oceania CQM. The management team have completed appropriate induction and orientation to their roles. Both the BCM and the CM have undertaken Oceania leadership training.</p> <p>Whareama Rest Home &amp; Hospital is certified provide services for up to 81 residents. At the time of the audit 12 beds were not in use resulting in 69 beds currently available for use. This included six rooms not in use, one room in use as a store room, one room repurposed as an office and two four-bedded rooms converted into two-bedded rooms.</p> <p>The facility is certified to provide rest home and hospital care services, with 56 beds occupied at the time of the audit. Occupancy included: 35 residents requiring rest home level care and 21 requiring hospital level care.</p> <p>The facility holds contracts with the DHB for respite care and long-term chronic conditions. Total occupancy numbers included three residents assessed as requiring rest home level care under the respite care agreement.</p> <p>The facility does not have any occupational right agreements.</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>	<p>FA</p>	<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 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 and also receive alerts through the electronic duty log on system.</p> <p>Service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators such as: falls; infections; medication errors; restraint; sentinel events; weight loss; wounds; and food safety; 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 and the electronic duty log on system.</p> <p>Monthly quality, health and safety and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. Staff interviews confirmed 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.</p> <p>Residents and family are notified of changes and events through the facility's monthly residents' meetings.</p>

		<p>Residents' meeting minutes, staff and resident interviews confirmed that residents, can have input into quality improvements and facility changes/equipment. Interviews confirmed that residents are satisfied that the service meets their individual needs and that they have input into services.</p> <p>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.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and their responsibilities to report hazards, accidents and incidents promptly. This is reiterated at health and safety and quality meetings. A maintenance person is the health and safety representative. Interview confirmed a clear understanding of the obligations of the role. Interviews with staff and the health and safety representative confirmed that the facility was proactive in encouraging hazard identification and reporting. 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 at each health and safety meeting, which is updated at least annually or when a new hazard is identified.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>FA</p>	<p>The CQM 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 three events that required reporting since the last audit. These included an influenza outbreak that was reported to the Nelson Marlborough Public Health, an unstageable pressure injury reported to the Ministry of Health and an investigation into the potential and unsubstantiated case of resident abuse also reported to the Ministry of Health. The appointment of the CM since the last audit had been reported to the Ministry of Health.</p> <p>Staff interviews confirmed an understanding of the processes. A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the BCM.</p> <p>Staff training records reviewed confirmed that staff receive education at orientation and as part of the ongoing training programme on incident and incident/accident reporting processes.</p> <p>Staff interviews described a 'no blame' environment for event reporting and 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.</p> <p>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</p>

		<p>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 incident/accident or a change in health status.</p> <p>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.</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>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.</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 and contractors that required them.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. Health care assistants (HCA) are paired with a senior HCA until they demonstrate competency on specific tasks, for example: hand hygiene; medication and moving and handling. Health care assistants confirmed their role in supporting and buddying new staff.</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 CM and nine other RNs have completed interRAI assessments training and competencies. Care staff complete annual competencies, for example: moving and handling; hoist use; hand washing; and medication management. Education session attendance records evidenced that ongoing education is provided relevant to the services delivered. 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 annual appraisal schedule is in place. All staff files reviewed evidenced a current performance appraisal.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>The facility staff consist of: a management team; RNs; HCAs; diversional therapist (DT), maintenance personnel and household staff. Household staff include: kitchen; laundry and cleaning staff who provide services seven days a week.</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>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 available to staff at least 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 sufficient RNs and HCAs, available to safely maintain the rosters for the provision of care. There is a pool of casual and part time 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.</p> <p>Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy and demonstrated that there are at least two RN on each morning and afternoon shift and one on each night shift.</p> <p>The CM and senior RNs share the 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 whilst they are busy at times, they have sufficient time to complete their scheduled tasks and resident cares.</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. An electronic medication system is used. Prescribing practices in line with legislation, protocols and guidelines were observed. The required three-monthly reviews by the GP or NP were recorded electronically.</p> <p>The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. Weekly checks and six monthly stocktakes of drugs are conducted and confirmed that stock matched expected levels. Pharmacy input was verified. All medications are stored appropriately. There are no standing orders used at the facility.</p> <p>The medication refrigerator temperatures are monitored. Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN confirmed this.</p> <p>The staff observed administering medication demonstrated knowledge and had a clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled.</p> <p>There were five residents in the rest home self-administering medication during the on-site audit. A process is in place to ensure ongoing competency of the residents and this is authorised by the GP. Medication is blister packed and stored securely.</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 28 February 2020.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and cool store. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated. Food temperatures are monitored appropriately and recorded daily.</p> <p>The kitchen was observed to be clean and cleaning schedules were sighted.</p> <p>The kitchen manager has undertaken a safe food handling qualification and all kitchen staff (excluding one who was completing orientation at the time of on-site audit) have relevant food hygiene and infection control training. Current food management training and certificates for cooks and kitchen staff were sighted.</p> <p>A nutritional assessment is undertaken for each resident on admission by an RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated 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, likes and dislikes of residents. These are accommodated in daily meal planning. Supplements are provided to residents with identified weight loss problems as medically required, however, use of supplements was not always documented in the PCCPs (refer to 1.3.6.1).</p> <p>Residents were seen to be given sufficient time to eat their meal and assistance was provided when necessary. There were sufficient staff to ensure appropriate assistance was available. Residents and families interviewed stated that they were satisfied with the meals provided.</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>	<p>PA Low</p>	<p>The PCCPs are completed by the RN and based on assessed needs, desired outcomes and goals of residents. However, not all PCCPs reviewed included sufficient interventions for weight loss and falls prevention and interventions were not always updated when the resident's condition changed.</p> <p>Family communication is recorded in the residents' files. The GP documentation and records reviewed were current. The GP interviewed stated the RNs contact them regarding any concerns in an appropriate and timely manner, and that there is effective communication. Interviews with residents and families confirmed that care and treatment met residents' 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>	<p>FA</p>	<p>The residents' activities programme is developed and overseen by two DTs, one in the rest home and one in the hospital. Activities for the residents are provided by the DTs five days a week. Weekend activities are planned by the DTs and implemented by the HCAs. The activities programme was displayed and implemented in both service areas. The activities programme reviewed provides variety in the content and includes a range of activities which incorporate education, leisure, cultural and community events. Van outings into the community are arranged once a week.</p> <p>The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on residents' interests, family and previous occupations are gathered during the interview with the resident and their family and documented.</p> <p>The residents' activity needs are reviewed six monthly at the same time the care plans are reviewed, and are part of the formal six monthly multidisciplinary review process.</p> <p>There was evidence the DTs take part in 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 hospital.</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 at handover and in the progress notes. If any change is noted, it is reported to the RN or CM.</p> <p>Person centred care plans are evaluated every six months or if there is a change in the resident's condition, in conjunction with the interRAI re-assessments. Evaluations are documented by the RN. The CM has a schedule, which was sighted, of when reviews were due to be completed with accurate records maintained. The evaluations include the degree of achievement towards meeting desired goals and outcomes. However, changes in the interventions are not always consistently initiated when the desired goals/outcomes are not achieved (refer 1.3.6.1).</p> <p>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 or added to the PCCP if ongoing.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>There is a current building warrant of fitness. Two four-bedded rooms have been converted into two-bedded rooms with a solid partition between each bed space that has not impacted on the floor plan or emergency evacuation</p>

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		plan. There have not been any structural alterations to the building since the last audit.
Standard 3.1: Infection control management  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.	FA	Click here to enter text
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	<p>The Oceania Healthcare Limited surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed. One of the RNs is the infection control nurse (ICN).</p> <p>Infection data is collated monthly by the ICN and CM and is submitted to Oceania national support office where benchmarking is completed. This data is analysed for trends and reported at the monthly infection control meeting and at the monthly staff and quality meeting for all staff.</p> <p>Interview with the CM confirmed there had been one outbreak of influenza since the previous audit. Review of documentation evidenced this was managed and reported as required.</p>
Standard 2.1.1: Restraint minimisation  Services demonstrate	FA	Policies and procedures meet the requirements of restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The CM is the restraint coordinator. Interviews confirmed understanding of the restraint minimisation and safe practice standard and the organisation's policies, procedures

<p>that the use of restraint is actively minimised.</p>		<p>and practice.</p> <p>A restraint register is maintained. On the day of audit there were three residents using restraints (chair briefs) and one using an enabler (bedrails). Restraint is used as the last resort after all other alternatives have been tried. Use of the enabler is voluntary. This was evident from documentation reviewed and staff interviews.</p> <p>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>
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## 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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Staff interviews confirmed that care is provided as outlined in the care plans. The RNs and HCAs report progress against the care plan on each shift at handover. However, care planning does not always include interventions in sufficient detail for long-term problems as per assessed needs in relation to falls prevention and weight loss. Two out of five resident files reviewed did not consistently include interventions around weight management and mobilisation post falls.</p> <p>Review of residents' files evidenced, when included, interventions were reviewed within the required timeframes. However, interventions were not consistently updated if there were changes in the condition of a resident.</p>	<p>i) Interventions related to weight and falls management are not always included in PCCPs.</p> <p>ii) Interventions were not always updated when there were changes in the</p>	<p>i) Ensure interventions related to weight and falls management are included in PCCPs.</p> <p>ii) Ensure interventions are updated when there were changes in the health status of a</p>

			health status of a resident.	resident.  90 days
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.