

# Oceania Care Company Limited - Everill Orr

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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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Everil Orr
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 3 September 2019      End date: 4 September 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	58

# 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

Oceania Healthcare Limited - Everil Orr can provide care for up to 65 residents requiring rest home or hospital level of care. The facility is certified to provide rest home, hospital, and residential disability - physical services. There were 58 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 by the consumer auditor, management, staff and a general practitioner.

There was one area relating to interRAI assessments and general practitioners' exemptions which required improvement at the last audit, this was implemented.

No areas were 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.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is provided to residents on admission and available within the facility.

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.

Staff communicate with residents and family members following any incident and this is recorded in resident 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.

## 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 Everil Orr.

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. Monthly reports to the national support office allow for the 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, 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 with current annual practicing certificates. The facility management team is supported by the regional clinical quality manager, the regional maintenance 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 for all staff members is provided. Annual interRAI updates for registered nurses occur.

A review of rosters and service delivery staff, and resident/family interviews confirmed that 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. Initial care plans guide service delivery during the first three weeks after admission.

The interRAI assessment process is used to identify residents' needs and this is completed within the required timeframes.

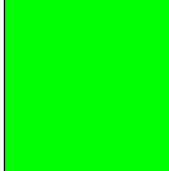
Electronic resident person centred care plans are individualised and based on a comprehensive and integrated range of clinical information. Short-term care plans are in place to manage short-term problems. Residents' records reviewed demonstrated their needs, goals and outcomes are identified and reviewed at regular intervals. Interviews confirmed residents and their families are informed and involved in care planning and evaluation of care. Handovers between all shifts guide continuity of care.

The activity programme is managed by two activity coordinators and the diversional therapy individual plans are reviewed by a diversional therapist. The programme provides residents with a variety of both individual and group activities. The service uses its facility van for outings in the community.

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

The facilities food service meets the nutritional and other specific needs of the residents. Staff have food safety qualifications. The kitchen was observed to be clean and meets food safety standards, is registered and has been audited for the service's food safety plan. Residents and family members 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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There is a current building warrant of fitness. 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.

There were two enablers in use and no residents using restraint at the time of audit. Restraint is only used as a last resort when all other options have been explored. When enablers are used, this is voluntary. Staff interviews confirmed understanding of the 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.
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Infection surveillance is undertaken, analysed and trended. Results are reported by the clinical manager to staff at the staff and quality meetings. Surveillance records showed evidence of follow-up of infection when required.

The infection surveillance programme is reviewed annually. Staff demonstrated current knowledge and practice in relation to the implementation of infection prevention and control.

## 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	0	0	0	0
<b>Criteria</b>	0	39	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)
<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>	<p>FA</p>	<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; 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 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 family were encouraged to raise any concerns and provide feedback on services. Residents' meeting minutes confirm that the complaints process is re-iterated at the meetings. Residents and family interviews confirmed that they were aware of a complaints process and that they could make a complaint. They stated that any issues raised had been dealt with effectively and efficiently. 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 has been an investigation of a patient's care conducted by the District Health Board (DHB) resulting in corrective actions required by the facility to review all short and long-term care plans to ensure these are appropriately detailed to ensure required care is documented, resident progress and care plans are reviewed and reflect the residents' current condition. The facility also undertook a review of the residents' specific care needs for registered nurses to learn more about the processes around bowel management. The corrective actions have been signed off by the DHB.</p>

		There have been no other complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy that sets out the process to guide staff to ensure 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 health needs.</p> <p>Family and resident 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.</p> <p>Two 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. These are advertised on the resident notice board and family are invited to attend the meetings. 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 for ease of reading. Residents and family are also provided with copies of upcoming planned activities and the menu. There is a monthly newsletter which includes events and updates such as, seasonal events and hairdresser appointment times. Interviews confirmed that the business and care manager (BCM) and staff were readily available, approachable and responded promptly to any issues/concerns raised.</p> <p>There are policies and procedures that provide guidance for staff, where English is not the resident's first language, to ensure interpreting services are available to these residents. It states that staff have access to a list of interpreting services and family may only interpret with a resident's consent.</p> <p>The facility has implemented a process to facilitate effective communication for any resident with a communication impairment.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Oceania Healthcare Limited (Oceania), Everil Orr Home and Hospital has a documented vision, mission and values statement which is displayed at the entrance to the resident lounge/dining area and reflects a person-centred approach to all residents, including young people with disabilities (YPD). These are also communicated to residents, family and staff through the internet and information provided to new residents and families on admission. Staff receive this information in their annual training.</p> <p>In addition to the overarching Oceania business plan, the facility has specific business planning objectives that are included within their annual budget that are specific to Everil Orr. Communication between the facility and executive management occurs monthly with the clinical and quality and operations managers providing support during the audit. The monthly reports from the facility provide the executive management team with progress</p>

		<p>against identified indicators.</p> <p>The BCM is supported by the clinical manager (CM). The BCM has been in the role for four years and the CM has been in their role for 11 years. Both the BCM and the CM hold current annual practising certificates and are supported by the Oceania clinical and quality manager (CQM).</p> <p>Everil Orr Home and Hospital can provide services for up to 65 residents. The facility is certified to provide rest home, hospital, and residential disability - physical services with 58 beds occupied at the time of the audit. Occupancy included: 20 residents requiring rest home level of care, including one young person with disabilities under the long-term chronic illness contract, and one YPD under this contract. In the hospital there were thirty-eight residents requiring hospital level care including four young people under the YPD contract. Of the four YPDs in the hospital; one has physical and intellectual disabilities with three having physical disabilities.</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.</p> <p>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>There is evidence that the annual 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. Service delivery is monitored through the organisation's reporting systems using clinical indicators such as: complaints; falls; infections; wounds; incidents and accidents; medication errors and implementation of the internal audit programme. There is communication with all staff of any subsequent changes to procedures and practice through meetings and staff notices.</p> <p>Residents' meeting minutes confirmed that YPD residents have input into quality improvements and facility equipment. Interviews by the consumer auditor confirmed that YPD residents are satisfied that services meet their individual needs and that they have input into services. Residents and family are notified of updates through the facility's residents' meetings.</p> <p>The organisation has a quality and risk management programme in place. Staff interviews reported that they are kept informed of quality improvements. Quality and staff meetings evidenced all aspects of quality improvement,</p>

		<p>risk management and clinical indicators are discussed. 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 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>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 of the need to report accidents and incidents promptly. There is a nominated health and safety representative for each staff group and interviews confirmed a clear understanding of the obligations of the role. Staff interviews confirmed an awareness of the process and their responsibility to report hazards. There is evidence of hazard identification forms completed when a hazard is identified and that hazards are managed, and risks minimised. A current hazard register is available that is reviewed and updated annually or when a new hazard is identified.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>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.</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 demonstrate that staff receive orientation and education on the incident and accident reporting process. 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>Incident reporting forms are readily available. Incident 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 were implemented. There is evidence of a corresponding note in the resident's progress notes and notification of the resident's family member where appropriate. A sentinel event was reported on a potential fire (smoke) from the steriliser in the sluice room. The area was evacuated, investigated and corrective actions were implemented. Corrective actions included buying a new steriliser, debriefing of staff and additional fire and evacuation staff training. The fire which occurred was reported as a section 31 event.</p> <p>Accident/incidents are graphed, trends analysed and benchmarking of data occurs 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. Skills and knowledge required for each position are documented in job descriptions. 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: registered nurses (RNs); the pharmacists; general practitioner (GP); dietitian; and podiatrist. Staff files reviewed demonstrate that recruitment processes for all staff include: reference checks; police vetting; identification verification; a position specific job descriptions; and a signed employment agreement.</p> <p>The orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on tasks, including personal cares for residents. Care staff complete annual competencies, for example: moving and handling; hoist use; hand washing; and infection control.</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, BCM and two RNs have completed interRAI assessments training, two RNS are in the process of being trained and one other RN is scheduled to start training. Education session attendance records evidenced that ongoing education is provided relevant to the services delivered including services for YPD residents. Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of relevant education and training hours per annum.</p> <p>An appraisal schedule is in place and all staff files reviewed for staff employed longer than one year, evidenced a current performance appraisal.</p> <p>The facility's staffing rationale informs recruitment processes to ensure suitable staff are appointed and available to meet the needs of all residents including those with non-acute medical conditions.</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 57 staff consisting of: the management team; RNs; health care assistants (HCA); activities coordinator; 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 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.</p> <p>Two RNs recently resigned. There is evidence that the service is currently advertising to replace these RNs and</p>

		<p>that current RNs cover the rosters safely. Registered nurses and HCAs are available to safely maintain the rosters for the provision of residents' care. There is a pool of casual HCAs available to supplement rosters when needed to accommodate increases in workloads and the acuity of residents such as additional hospital level residents. 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.</p> <p>The BCM and CM are 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 meet their needs. Staff confirmed that they have 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>	FA	<p>The medicine management system is documented and implemented and complies with legislation, protocols and guidelines.</p> <p>The service uses pharmacy pre-packaged medicine that is checked by a RN on delivery. An electronic medication system is used. Weekly checks and six-monthly stocktakes are conducted.</p> <p>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. Review of the medication fridge confirmed that the service does not store or hold vaccines. Interviews with the registered nurse and the CM confirmed they do not hold any vaccines on the premises.</p> <p>The staff member observed during audit, administered medication in compliance with the facility's medicine administration policies and procedures. Current medication competencies were evident in staff files sampled.</p> <p>There were no residents, including YDP, who self-administer medication during the onsite audit days. A process is in place to ensure ongoing competency of the resident if this is authorised by the GP.</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>	FA	<p>All meals are prepared on site and served in the main dining room. A small dining area in the hospital wing is also used for the hospital level residents. The seasonal menu has been reviewed by a dietitian. The food control plan's expiry date for implementation is 17 April 2020. Kitchen staff have current food management certificates. Diets are modified as required and the chef confirmed awareness of the dietary needs of residents.</p> <p>Residents' dietary profiles are developed on admission and identify the residents' dietary requirements and preferences. The dietary profiles are communicated to 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. Supplements are provided to residents with identified weight loss problems.</p> <p>All food procurement, production, preparation, storage, delivery and disposal comply with legislative requirements. The chef is responsible for purchasing the food to meet the requirements of the menu plans. Food</p>

		is stored appropriately in fridges which are monitored daily and dry food supplies are stored in the pantry.
<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 the residents. Care planning includes specific interventions for both long-term and acute problems.</p> <p>The GP documentation and records are current. Interviews with residents and families confirmed that care and treatment meet residents' needs. Staff interviews confirmed they are familiar with the needs of the residents. Family communication is recorded in the communication records in the residents' files. The nursing progress notes and observation records are 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 two activities coordinators and overseen by a diversional therapist employed by Oceania. The two activities coordinators provide activities Monday to Saturday. Health care assistants cover and provide activities for the residents on a Sunday such as movies and music sessions. Family visits and outings are encouraged on a Sunday. The activities programme was reviewed, displayed and implemented.</p> <p>The residents' activities assessments are completed within the three weeks of the residents' admissions to the facility. Information on resident's interests are gathered during an interview with the resident and their family. The activities coordinators develops separate activity care plans that reflects the individual resident's preferred activities. Residents under 65years have their own documented care plans that include all activities that the YPD person enjoy. Outing are arranged as able to meet the individual needs of all under 65yrs (YPD) residents. The 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 evaluation 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 and outings. Resident meetings are conducted bi-monthly and minutes of meetings were sighted.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	FA	<p>The long term care plans are evaluated six monthly. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Residents' responses to their treatment are documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved.</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. Family interviewed validated that they were contacted if</p>

timely manner.		there was any incident and/or change in condition of their relative.
<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>	FA	A current building warrant of fitness is displayed in the entrance to the current facility. There have been no building alterations to the facility since the last audit.
<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>	FA	<p>Surveillance is appropriate to that recommended for long term residential care facilities and includes identified infections such as: urinary; soft tissue; eye; gastro-intestinal; upper and lower respiratory; skin infections and wounds. The RN/infection control nurse has recently resigned, and the CM is the current infection control nurse (ICN). The ICN reviews all reported infections and these are documented. New infections and any required management plan is discussed at handover to ensure early detection occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible aetiology and any required actions. Results of surveillance are shared with staff via staff and quality meetings and at staff handovers. Graphs are produced to identify any trends and comparisons with previous years and this is reported to management. There have been no outbreaks 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>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both enablers and restraints. The restraint coordinator interviewed is an experienced RN who provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisations policies, procedures and practice and the responsibility of the role.</p> <p>On the day of the audit two enablers were in use and no restraints were being utilised.</p>



## Specific results for criterion where corrective actions are required

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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
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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.