

Oceania Care Company Limited - Eldon Rest Home

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: Eldon 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: 12 November 2019 End date: 13 November 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: 83

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Eldon Rest Home is a facility within Oceania Healthcare Limited that can provide care for up to 103 residents requiring rest home or hospital level of care. There were 83 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.

Areas requiring improvement at the last certification audit relating to adverse event reporting, service provision and assessments have been closed.

There were no areas identified as requiring improvement at this 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.

Staff communicate with residents and family members following any incident.

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.
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Oceania Healthcare Limited is the governing body responsible for the services provided at Eldon Rest Home.

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 are in place. An internal audit programme is implemented. Corrective action plans are documented from quality activity results, 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.		Standards applicable to this service fully attained.
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The needs assessment service coordinators complete assessments for all residents, prior to their admission to the facility. On admission, residents' needs are assessed by the multidisciplinary team. InterRAI assessments, and other risk assessments, are completed by registered nurses and form the basis of person-centred-care plans. Residents and their families are informed and

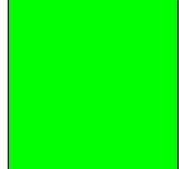
involved in care planning and the evaluation of care. Handovers, progress notes, diaries, medical and allied health notes provide continuity of care.

Recreational programmes provide residents with individual and group activities, including person specific activities for younger people.

The service has an electronic medicines management system which is aligned with legislative requirements and guidelines. Staff responsible for medication management have attended education and complete annual medication competencies. Residents who self-administer medicines have three monthly competencies completed.

All food is cooked on site. Nutritional needs of residents are assessed on admission and additional requirements and/or modified needs are met. The service has a current food plan. The menu is reviewed by a dietitian at a national level. Residents interviewed confirmed satisfaction with the food service.

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.

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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Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The staff interviews confirmed that enabler use is voluntary. There were residents using enablers. The service was restraint-free during the on-site audit. The assessment, consent, care planning and review of enabler use, is completed and recorded.

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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The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided. There have been no outbreaks since the previous 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
<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; the category and a summary of the complaint; how the complainant was contacted; 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 managed in line with Right 10 of the Code and are investigated promptly and resolved in a timely manner.</p> <p>Staff and residents' interviews and residents' meeting minutes confirmed that residents can raise and discuss concerns and issues at residents' meetings. Residents' and family interviews confirmed that they were aware of the process to make a complaint and felt comfortable doing so. 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 had been no complaints to external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p>	<p>FA</p>	<p>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 and residents' records reviewed, demonstrated that family are informed if the resident has an accident/incident; a</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>change in health or a change in needs. Family and residents' 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>There are two resident meetings every two months, one for hospital residents and a separate one for rest home residents. Family are welcome to attend the meetings. Meetings inform residents of facility events and activities and provide attendees with an opportunity to make suggestions and provide feedback. Residents are notified of upcoming meetings through the monthly activities planner. Minutes from the residents' meetings showed evidence that a range of subjects and issues are discussed, including: activities; food service; laundry; maintenance; facility changes; resident surveys and updates on aspects of the Code of Health and Disability Services Consumers' Rights (the Code) such as residents' rights.</p> <p>Meeting minutes identified that residents were able to raise and discuss any issues or concerns and that these are responded to.</p> <p>There is a 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. Interview with the business and care manager (BCM) confirmed that in the event that interpreter services are required these would be accessed through Wellington interpreter services or if the resident so wished, a family member.</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 strategic plan and mission, vision and values statements which reflect a person/family-centred approach to all residents. The values are displayed in the foyer. These are described in the information pack provided to residents and their families on admission. Staff also receive this information in the orientation welcome pack and in annual training. Oceania has an overarching business plan applicable to this facility.</p> <p>Eldon Rest Home is part of the Oceania group with the executive management team providing support to their facility. Communication between the facility and executive management occurs at least monthly. 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 has been in this role for 15 months. The BCM is a registered nurse (RN) with a current practicing certificate and has 17 years' experience in age related residential care (ARRC) facility management roles, including clinical manager (CM) and has 1 year's experience in a regional quality managers' role. The BCM is supported by a CM, who has been in this current role for nearly one year and has seven years' experience with Oceania, including four years in other clinical management roles. The CM holds a current annual practising certificate and is supported by the Oceania clinical quality manager (CQM). The management team have completed appropriate induction and orientation to their roles.</p> <p>The facility is certified to provide rest home and hospital care services for up to 103 residents, with 83 beds occupied at the time of the audit. Occupancy included: 24 residents requiring rest home level care, and 59 requiring</p>

		<p>hospital level care. Total occupancy numbers included: one resident assessed as requiring hospital level care under long-term chronic health conditions and one resident assessed as requiring rest home level care under the residential non-aged care agreement (YPD).</p> <p>The facility holds contracts with the district health board (DHB) for ARRC, long-term chronic health conditions; respite care and residential non-aged care agreement.</p> <p>The facility had no residents with 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 Oceania documented quality and risk management framework is accessed by 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 in the staff room. Staff interviews confirmed that they are made aware of new and updated policies.</p> <p>Service delivery is monitored through the organisation's reporting systems utilising a range of clinical indicators such as: absconders; complaints; falls; infections; medication errors; restraint; sentinel events; weight loss; and wounds. 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 from quality activities are developed, implemented, evaluated and closed out. Staff interviews confirm that they are advised of any subsequent changes to procedures and practice through meetings.</p> <p>All aspects of quality improvement, risk management and clinical indicators are discussed at monthly meetings. Copies of meeting minutes are available for review in the staff room. Staff interviews confirmed that they are kept informed of quality improvements. Residents and family are notified of facility changes and events through the facility's residents' meetings. Residents' meeting minutes, staff and resident and family interviews confirmed that residents can have input into quality improvements and facility changes. Interviews with residents and family confirmed that residents, including YPD, are satisfied that the service meets their individual needs and that they are provided with choices, and have access to technology, aids, equipment and services.</p> <p>Satisfaction surveys for residents and family are completed as part of the annual internal audit programme. Surveys reviewed evidenced satisfaction with the services provided. This was confirmed by residents' and family interviews. There was evidence that corrective actions were developed and implemented for opportunities for improvement arising from resident satisfaction surveys.</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</p>

		<p>responsibilities to report hazards, accidents and incidents promptly. Accidents, incidents and corrective actions are discussed at staff meetings. There are three health and safety representatives and one has completed health and safety training to stage four. Interview confirmed understanding of the obligations and scope of this role. There is evidence of organisational activities to promote the identification and reporting of hazards. Identification forms completed when a hazard is identified and that hazards are addressed, and risks minimised. A current hazard register is available and sections of this register is reviewed at each monthly health and safety meeting, ensuring that all hazards are updated at least annually.</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. Reports to the Ministry of Health since the last audit included: the appointment of both the BCM and the CM; two residents absconding; a trespass event and six pressure injuries.</p> <p>Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the BCM or the CM.</p> <p>Staff training records reviewed confirmed that staff receive education at orientation and as part of the ongoing training programme on accident/incident reporting processes. This includes training and discussion at staff and quality meetings on post falls observations.</p> <p>Accident/incident reports reviewed at audit evidenced that where appropriate, the resident's family had been notified, an assessment had been conducted and observations completed. This includes all unwitnessed falls and those with a suspected head trauma having neurological observation completed for 24 hours and assessed by the general practitioner (GP). Accident/incident reports demonstrated that post falls assessments had been undertaken. 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/incident or a change in health status.</p> <p>Accident/incidents are graphed, trends analysed and benchmarking of data is occurring with other Oceania facilities. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared at monthly staff meetings. Meeting minutes reviewed demonstrated that actions arising from meeting minutes include timeframes and responsibilities and are signed off. Minutes also demonstrate that restraint is discussed with staff monthly.</p> <p>The requirements for improvement at the last audit relating to adverse event reporting have been closed.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The 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; drug screening 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 buddied with an experienced staff member for at least three days and until they demonstrate competency on specific tasks, for example: hand hygiene; and moving and handling.</p> <p>The organisation has a documented role specific mandatory annual education and training module/schedule that includes topics relevant to all services and levels of care provided. 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 eight other RNs have completed interRAI assessments training and competencies. Care staff complete annual competencies and comprehension, 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 that staff employed for greater than one year had completed a current performance appraisal. Staff who had been employed for less than one year had completed an orientation review after three months.</p> <p>There are sufficient care staff appointed to safely meet the needs of all residents.</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</p>	<p>FA</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 of residents, and ensure that there is the appropriate skill mix of staff available. When required, additional staff are rostered on duty. For example: to meet resident needs where residents became unwell. Extra hours are allocated to relieve RNs on the floor within their rostered shifts, to ensure care planning and interRAI assessments are completed in a timely manner.</p> <p>There is one wing for rest home residents only and two dual purpose wings that accommodate predominantly hospital residents. The rest home wing has 23 beds, and the dual-purpose wings have 41 and 36 beds respectively.</p>

service providers.		<p>Each wing has a nurses' station. Staffing is adjusted as residents' acuity changes.</p> <p>There are sufficient RNs and HCAs available to safely maintain the rosters for the provision of care. Rosters sighted reflect adequate staffing levels to meet current resident acuity and bed occupancy. The BCM and CM are on morning duty Monday to Friday each week. In the rest home wing there is one charge nurse (CN) on the morning shift Monday to Friday and two HCAs; two HCAs in the morning and afternoon and one HCA at night, seven days per week. A RN from a dual-purpose wing provides RN cover for the rest home wing in the weekends, afternoons and at night. In the smaller dual-purpose wing in the morning, there is a CN Monday to Friday, plus one RN on each shift seven days per week, supported by six HCAs in the morning, four in the afternoon and two at night. In the larger dual-purpose wing in the morning, there is a CN Monday to Friday, plus one RN on each shift seven days per week, supported by eight HCAs in the morning, five in the afternoon and two at nights. All RNs and some HCAs have current first aid certificates.</p> <p>The BCM and CM share the on call after hours, seven days a week.</p> <p>Observation of service delivery confirmed that residents' needs are being met in a timely manner. Residents and family interviews stated that staffing levels meet the residents' needs. Staff confirmed that 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>	FA	<p>The medication areas evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Review of the medication register demonstrated this is maintained and evidenced weekly checks and six-monthly physical stock takes. The medication fridge temperatures are completed daily and recorded.</p> <p>All staff authorised to administer medicines have current competencies. The medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and followed procedures and protocols.</p> <p>Electronic medicine charts showed residents' photo identification, legibility, documentation of allergies, with three-monthly medicine reviews completed. The residents' medicine charts record all medications taken by residents. Pro re nata (PRN) prescribing practice meet the requirements of the standard and special authority medication approvals are current for residents who require these.</p> <p>There were two resident self-administering medicine at the facility and this was conducted according to policy. The policy includes facilitation for YPD residents to self-administer medicines. At the time of audit there were no YPD residents able to meet the criteria for self-administration of medicines.</p>
Standard 1.3.13:	FA	In interview, the kitchen manager confirmed they are aware of the residents' individual dietary needs. The residents'

<p>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>dietary requirements are identified on admission, documented and communicated to kitchen staff. The residents' dietary needs are reviewed six monthly or when a residents' condition changes. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at staff interviews.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weights. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided.</p> <p>The food temperatures are recorded, as are the fridge, chiller and freezer temperatures. All decanted food is dated. Kitchen staff have completed food safety training. The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu.</p> <p>The service has a current approved food plan.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Nursing assessments are completed within 24 hours of the resident's admission and informs the initial care plan. Over the following three weeks the residents' needs, outcomes and goals are identified through the interRAI assessment process and inform the person-centred care plans. Assessments are recorded, reflecting data from a range of sources, including; the resident; family; GP; specialist and the referrer. Policies and protocols are in place to ensure continuity of service delivery. Nutrition and pain are assessed on admission and as needed, and weights and general observations are monitored on a weekly to monthly basis dependant on needs.</p> <p>Wound assessment and wound management plans are in place. All wounds are assessed, reviewed, photographed and managed within the stated timeframes. The CNs stated on interview, that they can access the DHB wound or continence specialist nurse if required. Assessment processes and the outcomes are communicated to staff at shift handovers, in communication books, progress notes, initial assessments and care plans.</p> <p>The service has appropriate resources and equipment. The assessments are conducted in a safe and appropriate environment, usually the resident's room. Interviews with residents and family confirmed their involvement in the assessments, care planning, review, treatment and evaluation of care.</p> <p>The previous requirement for improvement relating to all wounds having to be assessed to provide information for wound care plans and treatments, has been implemented.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	FA	<p>The residents' care plans evidenced interventions based on assessed needs and desired outcomes/goals of the residents. The GP documentation and records reviewed were current.</p> <p>In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs.</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the residents they are allocated.</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>There is an activities programme for the rest home and hospital residents which includes activities for the residents under 65 years of age. There are various areas where recreational activities are provided. Regular exercises and outings are provided for those residents able to participate. The activities programme includes input from external agencies, planned activities such as festive occasions and celebrations, and supports ordinary unplanned/spontaneous activities. There are current individualised activities assessments and care plans recorded in the residents' files reviewed. The residents' activities attendance records are maintained. Feedback is obtained from residents and family members by way of satisfaction surveys.</p> <p>In interview, the diversional therapist (DT) confirmed their role in implementing the facility's activities programme, six days a week.</p> <p>During the on-site audit there were two young people with disabilities in the facility, each under a different contract. The DT documented individualised care plans that were consistent with the residents' needs and preferences.</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>Timeframes for care planning evaluations are documented and implemented. The residents' care plans are up-to-date and reviewed six-monthly. There is evidence of resident, family, HCAs, allied health staff and GP input into the care plan evaluations. In interviews, residents and families confirmed their participation in care plan evaluations. Wound care plans reviewed evidenced wound management plans were current and evaluated within the required timeframes.</p> <p>The residents' progress records are entered on each shift. When residents' progress is different than expected the RN or CN contacts the GP, as required. Short-term care plans are documented in residents' files where required. The family are notified of any changes in a resident's condition and this was confirmed at family interviews.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, where this is required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	<p>FA</p>	<p>The facility has a current building warrant of fitness. There have been no structural alterations since the previous audit.</p>

<p>provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection control nurse is the CM and is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at monthly clinical meetings.</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files evidenced the residents' who are diagnosed with an infection have short-term care plans.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the infection control nurse, RN's, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interview, the infection control nurse confirmed no outbreak has occurred at the facility since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint and enabler policy documents definitions congruent with the definition in the standards. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There were five residents at the facility using enablers and no residents using restraint at the time of audit. Enablers are in the form of bedrails and positioning belts.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, was confirmed at staff and management interviews.</p> <p>In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice, enabler usage and prevention and/or de-escalation education and training is provided.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.