

# Olive Tree Holdings Limited - Olive Tree Rest Home

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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 Health and Disability Auditing New Zealand 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:** Olive Tree Holdings Limited

**Premises audited:** Olive Tree Rest Home

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

**Dates of audit:** Start date: 21 October 2019      End date: 21 October 2019

**Proposed changes to current services (if any):** This audit included assessing six rooms (previously ORAs) as suitable for dual purpose. This configuration of beds gives a total of 51 beds available including 26 dual purpose beds, eight rest home beds and 17 dementia care beds.

**Total beds occupied across all premises included in the audit on the first day of the audit: 47**



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

## General overview of the audit

Olive Tree Rest Home is part of the Arvida aged care residential group. The service provides rest home and hospital level care for up to 51 residents. On the day of the audit, there were 47 residents. The residents and relatives commented positively on the care and services provided at Olive Tree.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Service Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff

The care services manager (an experienced registered nurse) is primarily responsible for the management of the care centre and clinical services with support and oversight from the village manager who oversees the daily operations of the village and provides support around human resource processes and financial management of the village. The management team are also supported by the general manager of wellness and care and the national quality manager.

The previous shortfall identified at their last audit around staffing has been addressed.

This surveillance audit identified improvements around initial interRAI assessments and care plan interventions.

The service has continued to maintain a continued improvement rating around infection surveillance.

## 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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Policies are implemented to support residents' rights, communication and complaints management. Management operate an open-door policy. Interviews with family and residents confirm there is open disclosure and the opportunity to feedback on the service through meetings and surveys. Complaints and concerns have been managed and a complaints register is maintained.

## 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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The quality and risk management programme includes service philosophy, goals and a quality/business planner. Meetings are held to discuss quality and risk management processes. Resident/family meetings are held regularly, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Falls prevention strategies are in place that includes the analysis of falls incidents. An education and training programme have been implemented. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The electronic resident files reviewed had individualised care plans and evaluations documented. Registered nurses are responsible for care plan development based on the interRAI outcomes and other assessments with input from residents and relatives. The general practitioner reviews the residents at least three monthly.

An activities programme is implemented by two wellness coordinators (DTs). The programme includes a diversity of activities and involvement with the wider community.

There is an electronic medication system in place, medication processes are in line with current legislation.


Meals are cooked on-site. Menus are reviewed by a registered dietitian. Any special dietary requirements and need for feeding assistance or modified equipment are recorded and being met. A current food control plan is in place. Nutritional snacks are available 24 hours a day.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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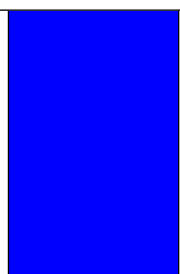
Olive Tree Rest Home has a current warrant of fitness. Preventative and reactive maintenance occurs. There is sufficient space to allow for the movement of residents using mobility aids.

## 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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Olive Tree Rest Home has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. One hospital resident had a bedrail restraint in use and eight residents were using bedrails as enablers (six hospital level and two dementia level residents). Policy dictates that enabler use is voluntary. Residents or their enacted enduring power of attorney have signed the consent forms.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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The type of surveillance undertaken is appropriate to the size and complexity of the facility. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Benchmarking occurs. There has been one respiratory outbreak in June 2019.

## 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>	1	13	0	2	0	0	0
<b>Criteria</b>	1	38	0	2	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 service has a complaints policy that describes the management of the complaints process and complaints forms are available. Information about complaints is provided on admission. Interview with residents and relatives demonstrated an understanding of the complaints process and stated the management team were approachable. There is a hard copy complaint register and since March 2019 the complaint register has been maintained on-line. Verbal and written complaints are documented. Six complaints have been made in 2018 and five complaints for 2019 to date. All complaints reviewed had noted acknowledgement, meetings, investigation and corrective actions within the required timeframes. The register identifies if the complainant is satisfied and offered independent advocacy where required. Concerns/complaints and corrective actions are discussed at facility meetings (as appropriate). All staff interviewed were able to describe the process around reporting complaints.</p> <p>The service has filed a report with the NZ nursing council June 2019 and forwarded documentation to the HDC as requested. The case remains open.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Residents (four rest home) interviewed and five relatives (of two hospital and three dementia care residents) stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident. Six incident/accidents forms reviewed (five falls</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>and one pressure injury) had documented evidence of family notification.</p> <p>Relatives interviewed confirmed that they are notified of any changes in their family member's health status. A residents meeting occurs at least two monthly and is open to families. The meeting agenda follows the five pillars of the living well model and provides residents and family with an opportunity to provide feedback on the service. There is a two monthly family meeting held in Silver Fern (dementia care unit). Regular newsletters are distributed to families and residents. Interpreter services are available as required.</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>The service provides care for up to 45 residents in the care centre. On the day of audit an additional six studio apartments (previously ORAs) were assessed as suitable for dual purpose rooms. This brings the total of beds available to 51 beds. There are eight rest home beds in one wing (Dahlia wing); 26 dual purpose beds in one wing (Camelia wing) and 17 dementia care beds (Silver Fern wing). On the day of audit there were 44 residents (three residents were currently hospital). There were 19 rest home residents (including one younger person), 11 hospital residents and 14 dementia level of care residents.</p> <p>The village manager is a non-practicing registered nurse with many years' experience in health management roles and has been in the current role for four years. She is supported by a care services manager/RN who has been at Olive Tree for six years and in the current role for four years. She is supported by a clinical lead who oversees the three areas. The management team are supported by the Arvida general manager for wellness and care and national quality manager. Monthly reports (clinical and non-clinical) are submitted to the Arvida general manager operations on a variety of operational issues.</p> <p>Arvida has an overall business/strategic plan and Olive Tree Retirement Village has an annual business plan in place. The organisation has a philosophy of care, which includes a mission statement. The business plan focuses on continuing to embed the living well model of care. A wellness coordinator has been appointed for Olive Tree.</p> <p>The village manager has completed at least eight hours of professional development including attending the two-day village manager forum annually covering health and safety, financial planning and wellness philosophy. The care services manager has completed at least eight hours of professional development in the past 12 months including health and safety and a dementia paper through the University of Tasmania. The care services manager is a careerforce assessor. The village manager and the care services manager attend provider forums at the DHB.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>FA</p>	<p>There is a quality plan that includes quality goals and risk management plans for Arvida Olive Tree. The village manager advised that she is responsible for providing oversight of the quality programme on-site, which is also monitored at an organisational level. The quality and risk management programme is also designed to monitor contractual and standards. There are weekly informal management meetings with formal monthly reports to support office. Staff meetings are held monthly. There are health and safety committee meetings and the minutes</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>are available on the staff room notice board including accident/incident and infection control data. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The service uses an electronic data base for the entering of data and collation of events.</p> <p>The service uses the Arvida suite of policies, which meet all current requirements and are reviewed at least every 2 years by the national quality manager. Head office sends new/updated policies. Staff have access to the policies on the intranet.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule is being completed. Areas of non-compliance identified through quality activities are actioned for improvement. Staff are informed of audit outcomes and corrective actions through the staff message board on eCase.</p> <p>Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families through meeting minutes and newsletters. The 2019 survey is in progress. The time of year for annual surveys has been shifted to later in the year to encourage a greater response rate. Resident/family meetings occur monthly for rest home/hospital residents and there are two monthly family meetings for relatives of dementia care residents in Silver Fern wing.</p> <p>The service has a health and safety management system that is regularly reviewed and meets legislative requirements. There is a health and safety committee that meet regularly to review incidents/accidents, hazards, health and safety practice and contractor compliance. Two health and safety representatives interviewed (maintenance person and apartment coordinator) are supported by the village manager, care services manager and the health and safety manager at support office. The health and safety representatives are involved in the health and safety induction of new staff including fire safety. The hazard register is reviewed annually.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</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</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The care services manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at management meetings and staff meetings, including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents. Six incident/accident forms were reviewed including three unwitnessed falls; however, neurological observations had not been commenced as per protocol (link 1.3.6.1).</p> <p>Discussions with the village manager and care services manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been four Section 31 notifications for pressure injuries including one resident with a stage three and unstageable non-facility acquired pressure injuries (June 2018), one resident with a stage three facility acquired pressure injury (March 2019), one resident with a stage four facility acquired pressure injury (May 2018) and one resident with a community acquired</p>

<p>their family/whānau of choice in an open manner.</p>		<p>unstageable pressure injury (July 2019). A respiratory outbreak in June 2019 was appropriately notified to Public Health.</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>There are human resource management policies in place. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. Annual practising certificates of professional staff are sighted, and a copy is kept on file. Five staff files were reviewed (one clinical lead/RN, one RN, two caregivers and one diversional therapist) evidenced reference checks were completed before employment was offered. There were job descriptions and completed orientations and annual staff appraisals evident in all staff files reviewed.</p> <p>The in-service education programme for 2018 has been completed and the plan for 2019 is being implemented. Altura on-line training has been implemented in 2019 and there is also on-site training provided by allied health professionals such as physiotherapist for safe manual handling/hoist training, hospice nurses, DHB nurse specialists and health and disability advocate. The care services manager and registered nurses attend external training as offered. The RNs are linked to the professional development recognition programme with the DHB. Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Staff attendance records are maintained. The care services manager is a careerforce assessor. Staff complete competences relevant to their role.</p> <p>There are nine RNs (including the care services manager), Seven of nine RNs have completed interRAI training and one RN is registered to attend.</p> <p>There are 12 caregivers who work in the dementia care unit. Eight have completed their dementia unit standards and there are four caregivers progressing through the dementia unit standards.</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>Olive Tree policies includes staff rationale and skill mix. Staffing rosters were sighted and there is staff on duty to match the needs of different shifts. Staff, families and residents interviewed felt there was enough staff on duty to meet the resident's needs.</p> <p>The care services manager works Monday to Friday and on-call.</p> <p>Silver Fern – 17 bed dementia unit with 14 residents on the day of audit. Staffing is as follows: There is an RN on duty in the dementia unit Monday, Wednesday and Thursdays each week. The care unit RN covers the dementia unit at other times. There are three caregivers on morning shift (two full shift and one finishing at 1.30pm). On afternoon shift there are three caregivers (two on full shift and one finishing at 9pm). There are two caregivers on night shift. There is a wellness coordinator Tuesday to Saturday.</p> <p>The care unit includes Camellia Wing – 26 dual purpose beds with 24 residents (12 rest home and 11 hospital level</p>

		<p>of care) and Dahlia Wing of eight rest home beds with seven rest home residents on the day of audit. There are two RNs Monday to Friday morning shifts and one RN on the morning shift in the weekends. There are five caregivers on the morning shift with three on the full shift and two on short shifts (one finishing at midday and the other finishing at 1.30 pm). There is one RN on the afternoon shift and three caregivers (one full shift, one finishing at 8.30pm and one finishing at 9.30pm). On night shift there is one RN and one caregiver.</p> <p>There is a DT Monday to Friday in the care unit.</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>Fourteen electronic medication charts reviewed (four hospital, six rest home and four dementia) met legislative requirements. Clinical staff that administer medications (RNs and senior caregivers) have been assessed for competency on an annual basis and attend annual medication education. The staff (RNs and caregivers) interviewed could describe their role regarding medication administration. All medication is checked on delivery against the medication chart by a registered nurse and any discrepancies are fed back to the pharmacy.</p> <p>Staff were observed to be safely administering medications in each area. Medication administration records reviewed showed that all prescribed medications had been administered.</p> <p>All medications are stored safely. The medication fridge is maintained within the acceptable temperature range. All eye drops and ointments were dated on opening. There were no residents self-medicating on the day of audit.</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>There is a large commercial kitchen where all food is prepared and served. All staff working in the kitchen have completed food safety certificates. There is a current food control plan in place. There is a four weekly summer menu in place which had input from the kitchen manager to accommodate resident requests and is has been reviewed by the dietitian. Fridge, freezer, chiller, and dishwasher temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained.</p> <p>The kitchen staff receive dietary information forms for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RN. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, gluten free, vegetarian, pureed and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met. Staff were observed assisting residents with meals in a respectful manner.</p> <p>Residents choose what they want to eat from the bain-maries in each dining room. The food is served by kitchen staff. There are two choices on main course available to residents each day. The kitchen has implemented a 'create your own dessert' day so residents can create their own dessert such as a banana split using a choice of fruit and toppings. If residents are unable to choose their meals from the bain-marie, the caregivers inform the resident of the choices available and plate the food for the resident. There is a 'residents choice' box in the dining</p>

		<p>rooms, where residents can provide suggestions or recipes for the kitchen staff to cook, the name of the resident who provided the recipe is identified on the menu board, so the resident knows the kitchen have used their recipe.</p> <p>Meals are delivered to the dementia unit in hot boxes.</p> <p>A hospital fridge has been a new initiative where staff have access to fortified snacks, high protein foods, puree fruit snacks and 'bowel mix'. This food is available for residents who require extra snacks.</p> <p>Residents at Olive Tree provide feedback and suggestions on the menu and food services through the resident meeting and resident surveys. Residents and relatives interviewed were very satisfied with the food and enjoy the buffet choices.</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>	PA Low	<p>When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. Progress notes were written by the RNs and caregivers completed worklogs created by the RNs based on the resident's assessed needs and care plan interventions, however not all interventions were reflective of the resident's current condition. GP notes reviewed were comprehensive and integrated in the resident's electronic records. Required follow-up after GP visits were completed by the RNs and these were recorded in the resident's notes. Referrals to other health services occur and consequently their recommendations were followed up. Short term care plans are not used, and not all long-term care plans included current interventions.</p> <p>There is evidence in the progress notes of communication with relatives. Discussions with relatives confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in treatment rooms. On the day of the audit, there were eight skin tears (five in the rest home and three in the hospital), two residents with surgical wounds, three residents with skin conditions (two in the rest home and one in the dementia unit), and six abrasions (three in the rest home and three in the hospital). A sample of wound charts were reviewed from each area, all had a wound assessment, plan and written evaluation documenting progression towards healing.</p> <p>Continance products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring forms are used for weight, vital signs, and blood sugar levels, pain, challenging behaviour, and food and fluid charts and neurological observations; however, not all neurological observations had been completed for unwitnessed falls.</p>
<p>Standard 1.3.7: Planned Activities</p>	FA	<p>There are two wellness coordinators (diversional therapists) employed at Olive Tree. Each resident admitted to the service has a section in their titled "about me", a social history completed in partnership with the resident and</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>relatives. A social activity plan is developed to include the personal preferences, hobbies and interests of the resident. This was evident in the resident files reviewed.</p> <p>Activities within the facility are combined across all service levels as much as possible. Combined activities include quizzes, word games, and entertainment. There are set activities held in the dementia unit to include exercises and walks, weekly van outings, newspaper reading.</p> <p>The programme is planned between Monday to Friday and integrated to meet the physical and psychosocial well-being of the residents. The programme includes new activities when requested by residents and is varied. There are regular outings for each unit into the community and regular entertainers. One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Craft activities include making hats in preparation for the Melbourne Cup, and cooking. The wellness team have incorporated dance into the exercise routines and introduced chair yoga (sighted during the audit). The happy hour continues and is enjoyed by the residents. Themes and events are celebrated.</p> <p>The specific needs of the younger resident are documented and addressed on a one-to-one basis, and include interests such as swimming, attending church and going out for a coffee.</p> <p>Resident meetings are held monthly, the residents interviewed report they have freedom to discuss concerns, suggestions for improvement. The Arvida Pillars are discussed, and the service endeavour to accommodate suggestions made.</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>The six long term files reviewed (one resident was recently admitted) identified that care plans were evaluated initially within three weeks of admission and thereafter at least six monthly. More frequent evaluations were sighted where progress is different from expected. Consequently, the RN responded by initiating changes to the care plan using appropriate assessment tools, however not all interventions were in place (link 1.3.6.1). The RN also creates worklogs for the caregivers to monitor and document progress against identified interventions.</p> <p>Resident and relative interviews confirmed that they were included and informed of all care plan updates and changes. Caregivers interviewed demonstrated knowledge of residents change in health status.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	<p>FA</p>	<p>Olive Tree has a current building warrant of fitness expiring on 31 July 2020. The maintenance person maintains records of preventative and reactive maintenance according to the Arvida template. All medical and electrical equipment has been calibrated, tagged and tested. Hot water temperatures are monitored and managed within expected ranges.</p> <p>The dementia unit has secure access. External areas are secure and well maintained with two entrances for residents to walk in a loop. There is a large lounge in the centre of the unit, small quiet seating areas throughout</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>the unit, and a small lounge at the end of the corridor with external access. The bedroom doors in the dementia unit are brightly coloured.</p> <p>The rest home and hospital area have two large communal dining areas and a large lounge area with smaller areas for quiet activities and private meetings with family/visitors in the rest home/serviced apartment areas. There is also a large activities room which residents' access for some activities (i.e., use of sewing machines and craft making) and a hairdresser salon</p> <p>The external areas are well maintained, and garden areas are attractive. The garden areas have furniture and shaded areas. There is wheelchair access to all areas. There are adequate communal toilets also located close to the dining room and lounge areas.</p> <p>The facility has wide corridors and spacious rooms to allow for easy access and movement and promotes independence for residents with mobility aids. Handrails are appropriately placed in the corridors and communal areas.</p> <p>Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>The service has requested a reconfiguration of resident rooms (MOH letter dated 13 May 2019). The reconfiguration relates to converting six serviced apartments in the Camellia wing to be used for dual purpose. These rooms were viewed on the day of the audit. Each room provides space for mobility equipment, bed and hoists if required. Each room has an ensuite facilities, which are large enough to accommodate a hoist and specialist showering chairs of needed. All rooms have call bell access in the bedroom and ensuite. The Camellia wing has one treatment room, and a sluice room. The nurse's station is within close proximity. The rooms were existing in a care centre wing as studio apartments and now changed to dual-purpose, therefore there is no change required to building/fire evac/civil defence supplies.</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>CI</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary with an end of month analysis. This data is monitored and evaluated monthly and annually. The service has continued to have low numbers of eye infections. Infection control data is posted on the staff notice board. Reports are easily accessible to the village manager. There has been one respiratory outbreak in June 2019. Notification to public health and daily case logs were sighted.</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 service has documented systems in place to ensure the use of restraint is actively minimised. There was one hospital resident with restraint (bedrails) and eight residents (six hospital and two dementia care) using an enabler (bedrails) during the audit. The resident or residents enacted enduring power of attorney has signed the consent form for enabler use. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	Initial interRAI assessments are completed within 21 days of admission in all files reviewed, however reassessments were not always completed within six-month timeframes. There is a suite of assessment tools available on the electronic system, which have been completed as appropriate for each resident in the files reviewed.	Six of seven files reviewed did not have interRAI reassessments consistently completed at least six monthly.	<p>Ensure interRAI timeframes are met.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and</p>	PA Low	The resident files reviewed had individualised care plans in place; however, not all of the care plans contained specific instructions to guide care staff on caring for the resident. Accident/incident forms for	<p>(i) Three of three residents did not have neurological observations completed as per protocol.</p> <p>(ii) There were no documented</p>	(i). Ensure neurological observations are

<p>contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>unwitnessed falls had been fully completed and evidenced RN follow-up; however, neurological observations had not been completed as per protocol for three of three unwitnessed falls reviewed.</p>	<p>interventions for; a) a hospital level resident with a current infection, b) a hospital level resident experiencing anxiety, c) a resident in the dementia unit who has behaviours that challenge, and d) a rest home resident with unintentional weight loss.</p>	<p>completed as per the policy. (ii). Ensure all care plans have interventions documented for residents' current needs.</p> <p>90 days</p>
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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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	The service has continued to maintain low eye infection rates by continuing to implement interventions around procedures for administering eye drops and education of staff and residents. There have been no eye infections in 2018 and 2019 until October 2019. The service has maintained the continued improvement rating around reduction of eye infections.	There has been continual improvement around eye care hygiene with specific eye kits, procedures, staff education around hand hygiene and cross contamination. A review of monthly infection control data identified there has been one current eye infection since the previous audit. The resident with an eye infection was also being treated for a chest infection. Ongoing infection control education (sighted) occurred for staff and residents. Staff were kept up to date at meetings.

End of the report.