Oceania Care Company Limited - Eldon Rest Home

Introduction

This report records the results of a Certification 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); Dementia care
Dates of audit:	Start date: 15 May 2018 End date: 16 May 2018

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: 88

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Eldon Rest Home is part of Oceania Healthcare Limited. Eldon Rest Home provided residential care for up to 133 residents. The service has since reduced their numbers to provide care for up to 126 residents. Occupancy at the time of the on-site audit was 88 residents.

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

Staffing is stable with minimal turnover. Staff hours are increased if required to meet the needs of residents. Residents and family interviewed provide positive feedback on the care provided.

There have been no changes to the building, staffing structure, management or systems since the previous audit. The business and care manager is responsible for the management of the facility and the clinical manager is responsible for clinical aspects of care.

Improvements are required in relation to adverse event management, timeframes around service delivery and wound care needs.

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.

Eldon Rest Home ensures information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is accessible and is given to new residents and their families on admission to the facility. Residents and family members interviewed confirmed that their rights are met during service delivery; they are treated with respect; there is open disclosure and they understand their rights. Residents and family confirmed that consent processes are discussed and on admission and time is provided when further explanation is required.

The business and care manager is responsible for the management of complaints and a complaints register is maintained. Residents and family have access to complaint forms and can raise issues at the residents' meetings, or can raise concerns directly with the business and care manager or staff.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Oceania Healthcare Limited is the governing body and is responsible for the service provided at Eldon Rest Home. The business and care manager is a registered nurse who is suitably qualified and experienced for the role, supported by a clinical manager, who is also a registered nurse, and who is responsible for clinical management and oversight of services. The clinical manager is supported by four charge nurses.

The service has a planned, documented quality and risk management system that supports the business management and provision of clinical care. Quality and risk performance is reported through meetings at the facility and is monitored by the organisation's management team through the business status reports and regional operations manager reports.

The quality programme includes a risk management system, including an internal audit programme, education and training, meetings, incident and accident monitoring, complaints management, and management of infection control, restraint and health and safety. The facility uses the company-wide electronic system to record and monitor key quality indicators and performance.

Human resource policies and procedures on human resources management and the validation of current annual practising certificates for personnel who require them to practise is occurring. In-service education is provided for staff, including required training in relation to dementia care. Review of staff records provide evidence that human resources processes are being followed.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Residents receive services from suitably experienced and qualified staff. The initial assessments, the initial care plans and the short-term care plans for acute conditions are conducted within the required timeframes. Nursing care plan evaluations are documented, resident-focused and indicate progress towards meeting the residents' desired outcomes. The residents and family members have an opportunity to contribute to care plans and evaluations of care.

Activities are planned and appropriate to the group setting. The residents and families interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis. The residents in the dementia unit have 24-hour activity plans completed.

Residents' referrals and exit from the service are conducted according to policy with all the required information provided to the health service.

The medicine management system is documented and implemented to provide safe processes for prescribing, administration and medication reconciliation, dispensing, storage and disposal of medicines. Medicine management training is provided. The medicines policy includes a section on the self-administration of medicines. At the time of the audit there was one resident self-administering medicines. Service providers responsible for medicines management complete annual competencies.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines. There is a central kitchen and on-site staff that provide the food service. The kitchen staff have completed food safety training.

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.

The facility has two hospital wings, a rest home and a (now closing) dementia unit. All but two rooms, where couples share, provide single accommodation. All of the rest home bedrooms have full ensuite facilities and some of the rooms in the hospital share a bathroom between two rooms. There are also adequate toilet and shower facilities throughout the facility.

Residents' rooms are large enough to allow for the safe use of mobility aids and staff. There are several lounges and dining areas throughout the facility with external areas providing seating and shade. The service has an appropriate call bell system with a security system to ensure resident safety.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and staff are familiar with requirements around their roles. Staff receive training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provided evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is worn. All laundry processes are provided on site and cleaning and laundry systems include appropriate monitoring systems. Staff have completed appropriate training in chemical safety.

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.

Restraint minimisation policy and procedures and the definitions of restraint and enablers are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

There were three residents using restraint and one resident requesting the use of an enabler on audit days. The assessments, consents, care planning and reviews are recorded for the residents requiring restraint and the resident using an enabler.

Staff education in restraint, de-escalation and challenging behaviour has been provided.

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.

The service provides an environment which minimises the risk of infections to residents, staff and visitors. Specialist infection prevention and control advice can be accessed from the district health board; microbiologist, general practitioners and infection control specialists if needed.

New employees are provided with training on infection control practices and there is ongoing infection control education available for all staff. Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and procedures and supported with staff education.

Aged residential care specific infection surveillance is undertaken, analysed, trended, benchmarked and results are reported through all levels of the organisation.

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	47	0	0	3	0	0
Criteria	0	98	0	0	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff receive training in the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights' (the Code) at least annually as confirmed in records sighted. Care staff were observed interacting respectfully and communicating appropriately with residents. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs. Residents and family members were able to verify that services are provided with dignity and respect, privacy is maintained, and individual needs and rights are upheld. Education relating to the Code and complaints is provided by Health and Disability Advocacy service and residents and families are invited to attend.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make	FA	The service information pack includes documentation regarding informed consent. The RNs discuss informed consent processes with residents and their families/whānau during the admission process. Staff confirmed their understanding of informed consent processes. The informed consent policy and procedure directs staff on how to obtain informed consent.

informed choices and give informed consent.		Guidelines for consent include consent for resuscitation/advance directives. Staff ensure that all residents are aware of treatment and interventions planned for them. All resident files identify that the required consents are obtained. A GP signs to state competence of residents when residents choose not to be resuscitated. Copies of legal documents such as enduring power of attorney (EPOA) for residents are retained at the facility where residents have named EPOAs. Staff interviews demonstrated a good understanding of informed consent processes. Residents who are able to make informed decisions, for example; residents in the dementia unit, have EPOAs appointed. Residents interviewed confirmed they have been made aware of and understand the principles of informed consent, informed consent information has been provided to them and that their choices and decisions are acted on.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Information on advocacy services is available at the entrance to the service along with nationwide advocate details. Admission pack is reviewed and provided evidence advocacy, complaints and Code of Rights information is included. There are policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates and these were reviewed. Staff training on the role of advocacy services is included in training on the Code which is provided annually to staff. Discussions with families and residents identified that the service provides opportunities for the family or EPOA to be involved in decisions. Resident files included information on residents' family/whānau and chosen social networks. Residents and family interviewed confirmed that advocacy support is available to them if required, including information on how to access a Health and Disability Advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their	FA	There are no set visiting hours and family reported that they are encouraged to visit at any time. Residents confirmed that they are supported and encouraged to access community services as part of the planned activities programme. The service also encourages community visits from entertainers and community groups.

community.		
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The BCM is responsible for complaints management and there are systems in place to manage the complaints processes. A complaints register is maintained. The complaints policy and procedures are in line with the Code and includes timeframes for responding to a complaint. Complaint forms are available at reception and the complaints register includes; the date the complaint was received; the source of the complaint; a description of the complaint; acknowledgement of the complaint and the date the complaint was resolved. There have been no complaints lodged with the Health and Disability Commission or other external authorities since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code of Rights and information on the advocacy service are displayed and are available at the facility and in the information pack provided to residents and family on admission to the facility. The business and care manager (BCM), the clinical manager (CM) and registered nurses (RN) provide opportunity to discuss any questions potential residents and their families may have during the admission process. Residents and family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to admission. The admission pack is reviewed and contains, but is not limited to, information on the Code, advocacy and complaints processes. The completed resident and family surveys indicated residents are aware of their rights and are satisfied with this aspect of service delivery. Residents and family interviewed received copies of the Oceania handbook. Families and residents are informed of the range of services including information included in the service and admission agreements (refer to 1.3.3.3). Residents interviewed confirmed they had access to an advocate when needed. The BCM advised that an advocate visits the facility on a regular basis and is also responsible for taking resident meetings.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and	FA	The service has a philosophy that promotes dignity, respect and quality of life and has policies and procedures in place that align with the requirements of the Privacy Act and Health and Information Privacy Code.

receive services in a manner that has regard for their dignity, privacy, and independence.		Residents and family confirmed that they are included in the care planning process and are addressed by their preferred name. Healthcare assistants stated that they support the residents' independence and encourage them to be independent. Residents' personal belongings are used to decorate and personalise their rooms. Discussions of a private nature are held in the residents' rooms and there are areas in the facility which can be used for private meetings. Healthcare assistants reported that they know how to ensure privacy for residents, including knocking on bedroom doors prior to entering rooms. Interviews with residents and family confirmed their privacy is respected. Staff have had education around abuse and neglect and are able to describe how to identify abuse and neglect. The general practitioner interviewed did not have concerns about residents being exposed to abuse or neglect. Residents are assisted to access spiritual support when needed and there are interdenominational services at least weekly. Values, beliefs and cultural aspects of care are recorded in residents' clinical files reviewed.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service implements the Māori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/whānau to practise their own beliefs are acknowledged in the Māori Health Plan. The diversional therapist completes cultural assessments on admission and reviews activity plans six monthly. There were no residents identifying as Māori living at the facility at the time of the on-site audit. Cultural training for staff is provided as part of the annual training programme. The organisation has a Māori Health Plan that includes the three principals of the Treaty of Waitangi: partnership, participation and protection. The Māori Health Plan describes that the holistic view of Māori health is to be incorporated into the delivery of services (whānau, hinengaro, tinana and wairua. Resident have access to Māori support and advocacy services if required. Healthcare assistants confirmed an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, they would have access to appropriate services.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture,	FA	Residents and families confirmed they are involved in the assessment and the care planning processes. Information gathered during assessments on admission includes the resident's

Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		cultural values and beliefs. The service has residents from other cultures and they confirmed during interview that their cultural needs are met. Documentation reviewed provided evidence that appropriate culturally safe practices are implemented and maintained. Residents' files reviewed demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whānau contact details. Residents interviewed confirmed their spiritual needs are met. Healthcare assistants confirm an understanding of cultural safety in relation to care and that processes are in place to ensure residents have access to appropriate services.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff files included guidelines regarding expected conduct and professional boundaries. Families and residents expressed no concerns with breaches in professional boundaries, discrimination or harassment. There are policies and procedures in place that outline the safeguards to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is also outlined in job descriptions and employment contracts. Review of the accident/incident reporting system, the complaints register and interview of the BCM, indicated that there are appropriate processes in place to ensure the safety of residents if staff present with unacceptable behaviour.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There is a staff education programme and staff could describe sound practice based on policies and procedures, care plans and information given to them on care. Staff can access information on good practice provided by governing bodies and specialists in the region (refer to 1.2.4.3; 1.3.3.3 and 1.3.4.2). Education is provided by specialist educators as part of the in-service education programme. Registered nurses attend compulsory education at the district health board (DHB) and RNs complete the professional development and recognition programme via the DHB.
Standard 1.1.9: Communication	FA	Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. The BCM confirmed interpreting services are available from the district health board. Resident admission agreements provide information around what is paid for by the service and by the resident (refer to 1.3.3.3). An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed provided evidence that communication with family members is documented in residents' records. There is evidence of communication with GPs (refer to 1.2.4.3). Residents interviewed confirmed that they are aware of the staff that are responsible for their care.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Eldon Rest Home (Eldon) is part of Oceania Healthcare Limited. The Oceania Healthcare Limited vision, values, mission statement and philosophy are displayed. The organisation has systems in place recording the scope, direction and goals of the organisation. The BCM provides monthly status reports to the support office. Reports include quality and risk management issues, occupancy numbers, human resource issues, quality improvements, internal audit outcomes and clinical indicators. The BCM is a registered nurse with a business management background. The BCM is supported by the regional clinical quality manager. The CM is responsible for overseeing clinical matters. The CM has been in this role for three years and the BCM has been in their role for 13 years. Eldon previously provided residential care for up to 133 residents. The service has since changed six double rooms into single rooms and a seventh room into a sensory treatment room, resulting in the facility now being able to provide care for up to 126 residents. This included providing care for up to 23 residents receiving dementia care, 80 residents at hospital level care, and 23 residents at rest home level care. Since the end of April 2018, the facility has been in the process of closing down the dementia unit, with the aim to have all residents who receive dementia level care, placed in appropriate care services by the end of May 2018. At the end of the on-site audit there was one resident still in the process of having placement organised. Interviews with family confirmed the process was supportive with the least possible stress to residents and families. Occupancy during the onsite audit was 88 residents. On the first day of audit there were 57 residents requiring hospital level care, including two residents under the young persons with disability (YPD) contract for residents who are under the age of 65. There were 26 residents receiving rest home care, including one resident under the YPD contract and 5 residents in the

		dementia unit. Eldon is currently certified to provide aged related residential care (rest home, hospital and dementia level care) and has contracts with the DHB to provide respite care, day care, and long-term support for chronic health conditions.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The service has appropriate systems in place to ensure the day-to-day operations of the service continues should the BCM or the CM be absent. The CM, with support from the clinical quality manager stands in when the BCM is absent. The BCM stands in for the CM when away and there is support from an administrator. Both the BCM and CM are on call after hours if required. Oceania support office provides additional support when needed. Job descriptions and interviews with the BCM and CM confirmed their responsibility and authority for their roles.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Eldon Rest Home uses the Oceania Healthcare Limited quality and risk management framework. Organisational policies and procedures guide service delivery. Policies are subject to reviews with all policies current. Policies are linked to the Health and Disability Sector Standard and are available to staff in hardcopy. New and revised policies are presented to staff to read and staff sign to say they have read and understood the policy. Staff interviewed stated they read new or revised policies. Staff interviewed reported they are kept informed of quality improvements. There are monthly joint staff/quality and joint health and safety/infection control meetings including RN meetings. There are monthly resident meetings in the rest home and hospital including opportunity for families from the dementia unit to attend. Template agendas are used during meetings (refer to 1.3.4.3). Service delivery is monitored through review of complaints, review of incidents and accidents with monthly analysis of data, surveillance of infections, and implementation of an internal audit programme. Corrective action plans are documented (refer to 1.3.4.3). Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Resident/family satisfaction surveys are completed six monthly and results documented. Internal audit schedules and completed audits were reviewed. Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed. Review of the

		quality improvement data provided evidence the data is being collected, collated, evaluated, and comprehensively analysed to identify trends and that this data is being reported to staff and to the governing body. The health and safety manual documents health and safety management systems including a health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements, and an emergency plan. Meeting minutes are reviewed by management and provided evidence of discussion and reporting on accident/ incidents; hazards; staff wellness programme, health and safety objectives and maintenance.
Standard 1.2.4: Adverse Event Reporting 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.	PA Moderate	Accident/incidents were recorded on an incident/accident reporting form. The CM enters incidents and accidents into the Oceania intranet as part of the monthly reporting process. The internal audit process includes review of incident and accident processes. Review of incident and accident records did not consistently include required corrective actions, including neurological observations and post falls assessments. Records also did not consistently show that GPs are informed when residents sustain injuries as a result of an incident or accident. Review of incident and accident records identified staff misunderstanding the rationale for completing neurological observations. Where issues were identified for improvement during RN meetings, the corrective action process did not consistently include timeframes for implementation or sign-off after implementation of changes. The template for RN meetings did not consistently include opportunity for discussing restraint matters. Communication with families following adverse events, or any change in resident's condition was evidenced in the residents' files reviewed. Staff receive education on communication and documentation of adverse events and interviews with staff demonstrated their awareness of the adverse event process.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	The service has written policies and procedures in relation to human resource management, including requirements in relation to skills and knowledge for each position. Job descriptions outline accountability, responsibilities and authority. These are reviewed on staff files along with employment agreements, reference checking, criminal vetting, drug testing, completed orientations and competency assessments. Copies of annual practising certificates were reviewed for all staff that require them to practice and were current. An orientation/induction programme is available and new staff are required to complete this prior

		to their commencement of care to residents. The BCM advised that staff complete orientation and induction at the time of employment. The orientation process, including completion of competencies, takes up to three months. Orientation for staff covers the essential components of the services provided. Care staff interviewed confirmed they have completed an orientation, including competency assessments. The service has a training and education programme with study days where a wide variety of topics are addressed, including compulsory training, which is presented by Oceania support office. The BCM is responsible for the in-service education programme. Staff interviews and review of the education programme, staff files and attendance records confirmed staff attend training. The service has eight RNs, including the CM who have completed InterRAI training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale in place for determining service provider levels and skill mixes to ensure safe service delivery. Registered nurses cover is 24 hours a day. On call after hour RN support and advice is provided by the BCM and CM. Care staff interviewed reported there is sufficient staff are available. Residents and families interviewed reported staff provide them with adequate care. Staff members who until recently worked in the dementia unit, are now working in the rest home and hospital. Visual observations during this audit confirmed suitable staff cover is provided.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Resident information is entered in an accurate and timely manner and stored securely. Clinical notes are current and accessible to clinical staff. Information containing sensitive resident information is not displayed in a way that it could be viewed by other residents, their families or members of the public. Entries are legible, dated and signed by the relevant healthcare assistant, RN or other staff member, including designation. Approved abbreviations are listed. The resident's national health index number, name, date of birth and general practitioner are used as the unique identifier. Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information.
Standard 1.3.1: Entry To Services	FA	When the need for service had been identified, it is planned, coordinated and delivered in a timely

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		and appropriate manner. Information about the services provided at the facility includes details of the services provided, its location and hours, how the service is accessed and identifies the process if a resident requires a change in the care provided. Files reviewed contained pre-entry screening processes, ensuring compliance with entry criteria. Signed admission agreements do not consistently meet contractual requirements (refer to 1.3.3.3).
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and coordinated manner, with an escort as appropriate. There is open disclosure through effective communication between all services, the resident and the family. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example of a review of a resident exiting the service with dementia, due to the dementia unit closing, evidenced the required information was communicated and provided in hardcopy to the new facility.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	Medication areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The drug register is maintained and evidenced weekly checks and six monthly physical stocktakes. A computerised medication management system is used at the facility and meets the current legislative requirements and safe practice guidelines. A safe system for medicine management and administration was observed. The staff observed demonstrated knowledge and understanding of their roles and responsibilities related to each stage of medicine management. All staff authorised to administer medicines have current competencies. Administration records are maintained, as are specimen signatures. Staff education in medicine management is provided. The records of temperatures for the medicine fridges has readings within the recommended range. Residents' who request to self-administer medicines are provided with secure storage for their medicines. An initial assessment to verify the resident's safety and competency to administer medicines is completed, however, an ongoing assessment was sighted to be conducted four-

		monthly for one resident who was self-administering their medication (refer to 1.3.3.3).
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by the kitchen team, according to the dietitian approved menus. The menus follow summer and winter patterns. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures are monitored appropriately. The kitchen staff have undertaken a safe food handling qualification and completed all relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the dementia unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet residents' nutritional needs, is readily available. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There was sufficient staff on duty in the dining rooms in all service areas at meal times to ensure assistance is available to residents as needed.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	When a referral is received, but the prospective resident does not meet the entry criteria or there is no vacancy, the local Needs Assessment and Service Coordination (NASC) coordinator is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. Interview with management and family confirmed the decision to close the dementia unit had been communicated to families and the management have been supportive in ensuring residents with dementia were provided with alternative placements.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely	PA Moderate	On admission, residents have their needs identified through a variety of information sources that include: NASC assessments; other service providers involved with the resident; the resident; family/whānau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the

manner.		privacy of the resident's bedroom with the resident and/or family/whānau present if requested. Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. Review of the wound care plans evidenced not all wounds have had wound assessments completed.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment findings in consultation with the resident and/or family/whānau, informs the care plan and describes the required support the resident needs to meet their goals and desired outcomes. Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes. Residents and family/whānau members expressed satisfaction with the care provided. There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.
Standard 1.3.7: Planned Activities 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.	FA	Interviews with the DT and an AC confirmed the residents' social assessments and past activity/recreational history is undertaken on admission to ascertain the residents' needs, interests, abilities and social requirements. The residents' activity needs are evaluated regularly and as part of the formal six-monthly care plan review. The residents' attendances and participation in activities are monitored and activities monthly progress reports are entered in the residents' clinical files. There were three activities programmes offered at the facility on audit days; hospital, rest home and dementia unit. The activities reflect the residents' goals, ordinary patterns of life and include normal community activities. A multisensory room was opened in April 2018 and the activities staff and management state the use of this room is increasing. The residents in the dementia unit are assessed to ensure challenging behaviours are managed appropriately and strategies are in place for minimising or managing the behaviours that challenge. This is recorded on the behavioural assessments, challenging behaviour care plans

		and 24-hour activities care plans. The activities are discussed at the residents' meetings and indicate residents' input is sought and responded to. Residents interviewed confirmed they find the programme meets their needs. The annual satisfaction surveys relating to the activities provided evidenced the rate of satisfaction increasing annually.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the residents' progress notes. If any change is noted it is reported to the RN or the CM. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan. A short-term care plan is initiated for short-term concerns, such as infections and wound care. Interviews, verified residents and family/whānau are included and informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP, RN or CM sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by RN, CM or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are documented processes for the management of waste and hazardous substances in place. Policies and procedures specify labelling requirements, including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. The hazard register was sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Interviews with the household staff confirmed training and education. There is provision and availability of personal protective clothing and equipment including: goggles/visors; gloves; aprons; footwear; and masks. During a tour of the facility, personal

		protective clothing and equipment was observed in areas where there are risks.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There have not been any alterations undertaken to the building since the last audit. A current building warrant of fitness is displayed. The service has a planned and reactive maintenance schedule implemented with a test and tag programme. Checking and calibration of clinical equipment is completed annually. The maintenance person has been in the role for about three years. During interview the maintenance person confirmed there is a maintenance programme in place that ensures buildings, plant and equipment are maintained. Residents interviewed confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. During the on-site audit the internal courtyards' spouting overflowed with evidence of needing maintenance. The roof of both the rest home and the hospital were observed to be extensively covered by lichen. Interview with the maintenance person and the BCM confirmed that the regional operations manager has been informed of the issues with the roof and the spouting and that the support office is in the process of looking at how this can be addressed. The BCM advised that the dementia unit is going to be demolished with Oceania looking at plans to build new care services of which not all the details are currently available. Interviews with staff and observation of the facility confirmed there is adequate equipment including: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. Corridors are wide enough in all areas to allow residents to pass each other safely. Safety rails are secure and are appropriately located; equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting. Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There are quiet areas throughout the facility for residents and visitors to meet providing privacy when required. There are four internal courtyards with other garden areas providing shade, seating and outdoor tables. Ramps and rails are at entrance doors for access for residents with disabilities. Residents interviewed confirmed they are able to move freely around the facility and that the accommodation meets their needs.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate	FA	Visual inspection provides evidence that toilet; shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Visitors' toilets and residents' toilets are located close to communal areas. All the toilets have a system that indicates if it is

toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		engaged or vacant. Residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence. Residents in a part of the hospital hare one bathroom between two residents. All other residents' rooms have ensuite bathroom facilities. Residents and family members reported that there are sufficient toilets and showers. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified. Hot water temperatures are monitored at monthly intervals and is delivered in line with the recommended temperature range. Interviews with the maintenance person confirmed that if the hot water temperatures exceed the recommended temperatures, corrective action is taken to address the issue.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space in bedrooms to allow residents and staff to safely move around in rooms. Equipment was sighted in hospital rooms with sufficient space for both the equipment and at least two staff and the resident. The residents' rooms are personalised with their own furnishings, photos and other personal possessions. Residents and families are encouraged to make the room their own.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The service has lounge/dining areas including areas that can be used for activities. Adequate access is provided to the lounges and the dining room areas with residents observed to being able to move freely. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Cleaning and laundry policies and procedures are documented and guide services at Eldon. There are processes in place for collection, transportation and delivery of linen and residents' personal clothing. The cleaners described the cleaning processes and schedules. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and monthly visits from the chemical company representative. Reports from the chemical company representative and completed audits for laundry and cleaning were reviewed. Cleaner described the management of

		cleaning processes including the use of personal protective equipment. There are safe and secure storage areas and staff have appropriate and adequate access to these areas, as required. Chemicals were labelled and stored safely within these areas. Sluice rooms are available for the disposal of soiled water/waste. Handwashing facilities are available throughout the facility. Residents and families stated they were satisfied with the cleaning service. The BCM stated there are internal quality improvement initiatives around the laundry services being implemented.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The service has a documented systems in place for essential, emergency and security services. Registered nurses, diversional therapists and personnel who drive the van with residents in it are required to complete first aid training. There is at least one designated staff member on each shift with appropriate first aid training. Emergency and security management education is provided at orientation and at the in-service education programme. Staff records sampled provides evidence of current training regarding fire, emergency and security education. A New Zealand Fire Service letter was sighted advising the fire evacuation scheme has been approved. Information in relation to emergency and security situations is readily available/displayed for staff and residents. Emergency equipment is accessible, current and stored appropriately with evidence of emergency lighting, torches, gas and barbeque for cooking, extra food supplies, emergency water and blankets. The service has a call bell system in place that is used by the residents, family and staff members to summon assistance. All residents have access to a call bell. Call bells are checked monthly by the maintenance person. Residents confirmed they have a call bell and staff respond to it in a timely manner. There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service. Visitors and contractors are required to sign in and out of visitors' registers.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an	FA	Procedures are in place to ensure the service is responsive to resident feedback regarding heating and ventilation in the facility. Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. Residents and family confirmed the facility is maintained at an appropriate temperature.

environment that is maintained at a safe and comfortable temperature.		
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The BCM is the infection control nurse (ICN) and has a job description for this position. The infection control policies and procedures clearly define the lines of accountability and responsibilities for infection control matters in the facility leading to the Oceania support office. The ICN is aware of processes for the required notification of infection control related issues. There is evidence of regular reports on infection related issues and these are communicated to staff and management. The Oceania company-wide infection control programme is reviewed annually by the Oceania infection control company-wide committee. The facility's infection control programme is reviewed at the facility. Visual information is located throughout the facility for visitors, staff and residents' awareness of infection control procedures to minimise the risk of infection. Staff confirmed in interview they were aware not to come to work if they were suspected or suffering from infections. On audit days there was evidence of prompt action taken to isolate a resident who was suspected of having an infection.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICN has the required knowledge and experience in infection control matters and participates in the local infection control meetings at the DHB. Expert advice is sought through the Oceania support office, GPs, microbiologist and the DHB. Interviewed staff reported that infection control issues are discussed at the facility's meetings. The ICN, CM and the RNs have access to records and diagnostic results of residents. The residents' files evidenced flu vaccines were conducted and signed consent forms were sighted. Implementation of the infection control programme is monitored via: the internal audits; staff education and training; and infection control documentation.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available	FA	The Oceania infection control policies and procedures manual provides information and resources to inform staff on infection prevention and control. The policies and procedures comply with relevant legislation and current accepted good practice and are reviewed regularly. On the audit days, staff were observed performing hand hygiene and using appropriate products for infection control. Interviewed staff reported that there are adequate infection control resources and equipment for use. Adequate quantities of personal protective equipment were sighted on

and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		audit days. Interviewed staff demonstrated awareness of infection control procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control training is conducted by the ICN or external educators, as part of the staff study days conducted on annual basis. Staff training records were sighted and confirmed this. Individual resident infection control education is conducted per rising need in a manner that recognises and meets the residents' communication method, style and preference. Interviewed staff reported that infection control is part of staff orientation for all staff and ongoing education is provided.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance for infection control is completed as specified in the infection control programme. The type of surveillance carried out is suitable to the type of services provided and the size of this facility. All staff participate in the surveillance activities managed and monitored by the ICN. Standardised definitions are used for identification and classification of infection events, indicators or outcomes. The surveillance findings and specific recommendations or interventions required to achieve infection reduction and prevention are recorded and shared in staff meetings and at shift handover times. Surveillance analysis is reported at monthly meetings and entered in the clinical indicators on the Oceania intranet. This information is reviewed by the Oceania clinical quality team and reported to the Oceania board monthly. Interventions are evaluated regularly on short-term care plans and signed off when infection is resolved. Interviewed staff demonstrated awareness of infection statistics and interventions in place to manage the infections. Management interviews confirmed there have been no outbreaks at the facility since 2014.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Oceania Healthcare Limited is focused on reducing restraint use nationally and have implemented strategies throughout the Oceania facilities, including in Eldon Lodge, to reduce restraint use. The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is

		recorded and implemented. There was one resident at the facility using an enabler and three residents using restraint on the days of the audit. The restraint and enabler use is documented in residents' care plans. Staff and management interviews confirmed the approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. The RN meeting minutes do not record the restraint as a standard agenda item (refer to 1.2.4.3).
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The Oceania Healthcare Limited clinical and quality team are responsible for approving any form or type of restraint practice used at Oceania facilities nationally. An annual review of the types of restraints used at Oceania facilities is discussed at the annual national restraint authority group meeting and policy on restraint approval is reviewed bi- annually. Oversight of restraint use at each individual Oceania facility is the responsibility of restraint coordinators. The restraint coordinator at Eldon Lodge is the CM and the responsibilities for this role are defined in the position description. 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. The restraint education and training is included in orientation and the staff mandatory study days. The staff restraint competencies are current. Restraints are authorised following a comprehensive assessment of the resident. The approval includes consultation with other members of the multidisciplinary team. The restraint consent forms evidence consent for restraint is obtained from the GP, restraint coordinator and the resident and/or a family member.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessments include: identification of restraint related risks; underlying causes for behaviour that requires restraint; existing advanced directives; past history of restraint use; history of abuse and or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. There was evidence that all enabler and restraint use was initiated following completion of appropriate assessments.
Standard 2.2.3: Safe Restraint Use	FA	The protocols on safe use of restraint detail the processes of assessment, approval and

Services use restraint safely		implementation and these guide staff in the safe use of restraint. Strategies are implemented prior to the use of restraint to prevent the resident from incurring injury for example: the use of low beds; mattresses and sensor mats. The policies that guide staff in the safe use of restraint document: the current approved forms of restraint; the indications for use; associated risks; safety precautions; and required authorisation, reporting and monitoring. There have been no adverse outcomes or sentinel events relating to restraint use reported to the Oceania support office. The restraint register is up to date and records all necessary information to provide an auditable trail of restraint events. Healthcare assistants are responsible for monitoring and completing restraint forms when the restraints is in use, evidence of this was sighted.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The evaluation of restraint occurs through restraint event reporting by the facility to the Oceania support office by measuring relevant clinical key performance indicators. Each individual episode of restraint is evaluated. The clinical files of residents using restraint evidenced the restraint evaluation forms are completed and these include all the relevant factors in this standard. The resident (if able) and their family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	There is evidence of monitoring and quality review of the use of restraints at the facility. There is evidence review of the compliance with the standard is conducted. The extent of restraint use and any trends identified across Oceania facilities is discussed at the annual national restraint authority group meeting. Monthly data recording the number of residents being restrained and residents requesting enablers are provided to the Oceania support office by the restraint coordinator at the facility and used as a review and for benchmarking purposes. The Oceania national restraint authority group meets annually to review the compliance with the restraint standard and review of restraint use nationally. The last Oceania national restraint authority group meeting was conducted in February 2018.

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)
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Incidents/accident records are completed for adverse, unplanned, or untoward events including service shortfalls. When residents have unobserved falls, neurological observations and post falls risk assessments are required to ensure the resident is safe from a potential head injury and reason for falling are reviewed. When a resident has a head injury, neurological observations are required to ensure the resident is safe. Incident and accident records did not consistently include neurological observation and where neurological observation were completed, it was not aligned with good practice. Where residents had head injuries as a result of an observed fall, staff did not consistently complete neurological observations due to the fact that the falls were observed. Observation, document review and staff interviews evidenced the rationale for completing neurological observations was not clearly understood. Post falls assessments were not consistently completed after falls and the incident/accident records do not indicate that the GP was informed where	1. Incident/accident records do not include evidence of: i) Neurological observations being completed for all unobserved falls (in case of a head injury). ii) Neurological observations continuing over	1. Incident accident records to include evidence of: i) Neurological observations being completed for all unobserved fall (in case of a head injury). ii) Neurological observations to continuing over 24 hours

		residents sustained serious injury. When RN meeting minutes showed that opportunity for improvement, the person responsible for making the changes was identified but the timeframes for implementation and sign-off were not documented. The RN meeting agenda template did not include a heading to ensure restraints are reviewed and discussed at monthly intervals.	24 hours. iii) Staff understanding that when a resident has an observed fall, they also need to have neurological observations completed (because of the head injury). iv) Residents who fall do not consistently have post falls assessments completed. 2. Registered nurse meeting minutes do not include evidence of: i) Timeframes for implementation of improvements or sign-off after implementation of changes. ii) The opportunity for staff to discuss restraint matters at monthly intervals.	(according to policy). iii) Ensure staff understanding the rationale for completing neurological observation and how it applies to unobserved falls as well as observed falls. iv) Residents who fall to consistently have post falls assessments completed. 2. Registered nurse meeting minutes to include evidence of: i) Timeframes for implementation of improvements and sign-off after implementation of changes. ii) To include the opportunity for staff to

				discuss restraint matters at monthly intervals. 60 days
Criterion 1.3.3.3 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.	PA Moderate	Residents who request to self-administer medicines are provided with secure storage for their medicines. An initial assessment to verify the resident's safety and competency to administer medicines is conducted, however, an ongoing assessment was sighted to be conducted four-monthly for one resident who was self-administering their medication. The residents' long-term care plans, including the activities care plans are not always completed within the three weeks of the resident's admission to the facility, evidenced in 3 of the 10 files reviewed. The GP initial assessments were completed on the residents' admissions, however, the three-monthly exceptions were not recorded in 5 of the 10 files reviewed. Review of 10 residents' admission agreements evidenced three admission agreements were not signed within the required 10 days post admission to the facility.	Timeframes are not always adhered to as required.	Provide evidence timeframes are adhered to as required. 60 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery	PA Moderate	The review of the wound care folders at the facility evidenced all wounds were recorded including but not limited to: skin tears; lesions; surgical wounds; haematomas; chronic wounds; abrasions; pressure injuries and lacerations. Of the 27 wounds there were 18 wounds that did not have wound assessments completed. The policy states the skin tears are to be recorded on short-term care plans for skin tear category 1a and 1b. The skin tear short-term care plans do not evidence wound assessments such as: assessment of the degree of tissue loss; skin colour; and surrounding skin assessment. There was evidence short-term care plans were used for skin tears of higher category such as 2a.	Not all wounds have had a wound assessment recorded.	Provide evidence all wounds are assessed to provide information for wound care plans and treatments.

planning.				60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.