

# Oceania Care Company Limited - The Oaks Rest Home and Village

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## 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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	The Oaks Rest Home and Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 20 September 2018    End date: 21 September 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	79

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

The Oaks Rest Home and Village provides rest home and hospital level care for up to 105 residents. There were 79 residents residing at the facility on audit days.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the district health board. The audit process included the review of policies and procedures, review of resident and staff files, and observations and interviews with residents, family members, management, staff, and a general practitioner.

The residents and family members spoke positively about the care provided.

There were eight areas identified as requiring improvement relating to: complaints management; collection of quality improvement data; corrective action plans; staff orientation; ongoing staff education and performance reviews; emergency management; timeframes of service delivery and restraint minimisation.

## Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process, and the Nationwide Health and Disability Advocacy Service is accessible. This information is brought to the attention of residents and their families on admission to the facility. Residents and family members confirmed their rights are being met; staff are respectful of their needs and communication is appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent is practised and written consent is gained when required. Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

There are policies and procedures about the management of complaints that align with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

## 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 low risk.
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Oceania Healthcare Limited is the governing body and is responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned. There are systems in place for monitoring the services provided, including regular monthly reporting by the business and care manager to the Oceania national support office.

The facility is managed by an experienced and qualified business and care manager who is a registered nurse with aged care experience and they have been in this position since March 2018. The clinical manager is responsible for the oversight of the clinical services in the facility.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented on accident/incident forms. Facility meetings are held where there is reporting on various clinical indicators, quality and risk issues, and discussion of identified trends. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resource management. A mandatory education programme is provided for staff.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice.

Resident information is entered into a register in an accurate and timely manner. The privacy of resident information is maintained. The name and designation of staff making entries in clinical files are recorded and legible.

## 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 medium or high risk and/or unattained and of low risk.</p>
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Residents' records sampled provided evidence that residents have been assessed appropriately prior to admission to this facility by the needs assessment service coordinators. Residents' needs are assessed by the multidisciplinary team on admission. InterRAI assessments, other risk assessments, care plans, and evaluations are completed by the registered nurses. Interviews confirmed residents and their families are informed and involved in care planning and the evaluation of care. Handovers, progress notes, diaries, medical and allied health notes guide continuity of care. Short-term care plans are in place for acute/short-term problems.

The activities programme provides residents with a variety of individual and group activities. Community outings are arranged. Entertainers and community groups are invited to participate in the programme.

Medicines are managed according to legislation and guidelines and are implemented using a computerised system. Staff responsible for medication management have attended annual education and completed annual medication competencies. Residents who self-administer medicines had three monthly competencies completed.

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

## 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>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The building has a current building warrant of fitness displayed. There is a reactive and preventative maintenance programme and this includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Residents' bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids, and to allow for care to be provided. Lounges, dining areas, and sitting alcoves are available for residents and their visitors. External areas and gardens are safe for residents to mobilise around.

A call bell system is available to allow residents to access help when needed. Security systems are in place with regular fire drills completed.

Protective equipment and clothing is provided and used by staff. Chemicals are safely stored. The laundry service is conducted off site apart from some residents' personal clothes which are cleaned on site. Cleaning of the facility is conducted by household staff and monitored.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Oceania Healthcare Limited policies and procedures on restraint and enabler use are current and reference best practice and legislation. There is a designated restraint coordinator and a restraint committee who oversee the restraint minimisation and safe practice at the facility. Enablers are used on a voluntary basis when a resident requests the use of an enabler. Staff receive training including all required aspects of restraint and enabler use, alternatives to restraint and dealing with challenging behaviours. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to residents, visitors and staff. The infection control nurse is responsible for the infection prevention and control at the facility, with support from management and staff. Infection control education is provided to staff at orientation and at ongoing education study days.



The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Infection data is collated monthly, analysed and reported at facility meetings and to the Oceania Healthcare Limited support office. Results are presented to staff.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	3	3	0	0
Criteria	0	93	0	5	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	Click here to enter text
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The informed consent policy guides staff in relation to informed consent and staff interviewed understood the principles and practice of informed consent.</p> <p>The residents' files evidenced documented consents using the organisation's standard consent form that includes consent for photographs, outings, and collection and sharing of health information. Consent is also obtained on an as-required basis, such as for influenza vaccinations.</p> <p>There was evidence of advance directives signed by the residents. Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with their relative and consulted when treatment changes were being considered.</p> <p>Staff were observed gaining verbal consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff (refer to 1.2.7.4 and 1.2.7.5). Staff demonstrated understanding of the advocacy service, with contact details for the service readily available at the facility.</p> <p>Residents are provided with information on the advocacy service as part of the admission process. Residents and family members confirmed their awareness of the service and how to access this.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to maintain their community interests and networks, and to visit with their families. The activities programme includes regular outings in the facility's mobility van and participation in community events. Community groups and entertainers also visit the facility.</p> <p>The service welcomes visitors and has unrestricted visiting hours. Family members advised they feel welcome when they visit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Moderate	<p>Policies and procedures relating to complaints management are compliant with Right 10 of the Code. Systems are in place that ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. The complaints forms are displayed and accessible within the facility. Staff interviews confirmed their awareness of the complaints processes. Residents and families demonstrated an understanding and awareness of these processes.</p> <p>The BCM is responsible for complaints management. There is one complaint being investigated by the Health and Disability Commissioner's office and review of the records evidenced the facility is providing additional information for this investigation to continue. There are no other complaints with other external agencies.</p> <p>The review of the 2017 and 2018 complaints did not evidence the required processes were consistently followed relating to Right 10 of the Code.</p>
<p>Standard 1.1.2: Consumer Rights During</p>	FA	<p>During the admission process, new residents and their family are given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service. Posters on the</p>

<p>Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>Code are displayed at the facility.</p> <p>Residents and family members interviewed were familiar with the Code and the advocacy service. Residents and family stated they would feel comfortable raising issues with staff and management.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff communicated their knowledge about the need to maintain residents' privacy and were observed doing so throughout the audit.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and outings, confirmed at residents and family interviews. Residents' care plans include documentation relating to residents' abilities and strategies to maximise independence. Residents' records sampled confirmed that residents' individual cultural, religious, social needs, values, and beliefs were identified, documented, and incorporated into their care plan.</p> <p>The policy on abuse and neglect was understood by staff interviewed, including what to do should there be any signs. Education on abuse and neglect is part of the staff orientation programme and in the mandatory staff study days (refer to 1.2.7.4 and 1.2.7.5).</p> <p>The residents and their families confirmed they receive services in a manner that has regard for their dignity, privacy, spirituality, and choices.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>The service has a Māori Health Plan that guides staff in meeting the needs of the residents who identify as Māori. Any additional cultural support, if required, would be accessed locally, confirmed at business and care manager (BCM) interview. At the time of the audit there was one resident who identified as Māori. The review of their clinical file and interview confirmed their individual cultural needs were being met.</p> <p>Family/whānau are able to visit their family members at the facility and are part of the care planning and evaluation care process. Interviews with family confirmed they were informed of their family member's changes in condition when this occurred, are invited to residents' meetings, receive newsletters, and are involved in multidisciplinary reviews.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And</p>	FA	<p>The individual preferences, values and beliefs of residents are documented in the care plans reviewed. Residents and family members stated they had been consulted about residents'</p>

<p>Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>individual ethnic, cultural, spiritual values, and beliefs, and confirmed that these were respected.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members stated that residents were free from any type of discrimination or exploitation.</p> <p>Staff are guided by policies and procedures and communicated understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. Staff orientation includes information related to all forms of discrimination and exploitation, professional boundaries and expected behaviours (refer to 1.2.7.4).</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The Oaks implements Oceania Healthcare Limited policies and procedures which are based on good practice, current legislation and relevant guidelines.</p> <p>The service encourages and promotes good practice through evidence-based policies and procedures, input from external specialist services and allied health professionals, for example: physiotherapists; and wound care specialists.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>A review of accident/incident forms showed timely communication with residents and or family members. Communication with family members is also recorded on the communication forms located in residents' clinical files. The residents and family members stated they were kept informed about any changes to their own or their relative's status, and were advised about incidents or accidents and the outcomes of medical reviews. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Residents and family members are informed of residents' meetings and the meeting minutes reviewed evidenced relevant information is shared.</p> <p>Interpreter services can be accessed via the district health board (DHB) or Interpreting New Zealand when required. This information is also provided to residents/families as part of the information/admission pack.</p>

<p><b>Standard 1.2.1: Governance</b></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 Oaks Rest Home and Village (The Oaks) is part of the Oceania Healthcare Limited (Oceania). The Oceania executive management team provide support to the facility with the regional clinical and quality manager providing the support during the on-site audit. The BCM provides the executive management team with monthly progress against identified indicators.</p> <p>There is a clear mission of the organisation with values and goals and these are communicated to residents, staff, and family through posters on the entrance to the facility and in information booklets.</p> <p>The BCM is responsible for the overall management of the service and has been in this role since March 2018. The BCM is a registered nurse (RN) and has experience in management of residential care facilities. The required authorities have been informed of the appointment of the BCM.</p> <p>The BCM is supported by a clinical manager (CM) who is responsible for the oversight of clinical services. The CM is an RN with experience in aged residential care. The CM was on leave at the time of the audit and the Oceania relief CM was assigned to this role.</p> <p>The facility can provide care for up to 105 residents, with 79 beds occupied at the audit. This included 30 residents requiring rest home level care and 49 residents requiring hospital level care. One resident was under a palliative contract and two residents under 65 years of age were receiving care under a long-term chronic condition contract.</p> <p>The facility includes hospital and rest home level services with occupational rights agreements (ORA). The services for residents with ORA are the same as services for rest home and hospital services for residents under the age-related residential care contract and other contracts at the facility.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>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.</p>	<p>FA</p>	<p>In the absence of the BCM, the CM is delegated to perform this role, with support from the regional operations manager and the regional clinical and quality manager. For extended leave of the BCM, Oceania's relief BCM would be assigned the responsibility, confirmed at management interviews. If the CM is on leave, the Oceania relief CM has oversight of clinical care.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p>	<p>PA Low</p>	<p>The Oaks uses the Oceania quality and risk management framework that is documented to guide practice.</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>The service implements organisational policies and procedures to support service delivery, including policies on interRAI. All policies are subject to reviews as required with all policies current. Support office reviews all policies with input from relevant staff and management. Policies are linked to the Health and Disability Sector Standards current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff. New and revised policies are presented to staff to read and staff sign to evidence that they have read and understood the policy. The staff confirmed that they are provided with new and revised policies and opportunity to read and understand the policy.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, key performance indicators, and implementation of an internal audit programme (refer to 1.1.13.3). The review of the quality management data evidenced the internal audit schedule was not consistently followed; the patient satisfaction survey was not collated and analysed, and corrective actions where required were not always documented or evidenced implementation.</p> <p>Facility meetings are conducted and minutes evidenced communication with staff around aspects of quality improvement and risk management. Staff report that they are kept informed of quality improvements.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed, and risks are minimised or isolated.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff understood the adverse event reporting process and were able to describe the importance of recording near misses. Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. Accident and incident forms are reviewed by management and signed off when completed. The registered nurses undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>Policy and procedures comply with essential notification reporting; for example, health and safety, human resources, and infection control. The BCM is aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks; and changes in key clinical managers. Authorities have been notified of a recent outbreak.</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>PA Low</p>	<p>Written policies and procedures in relation to human resource management are available. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice. The selection and approval of new staff is the responsibility of the BCM. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities, and authority. These were reviewed on staff files along with employment agreements, reference checks, and police vetting.</p> <p>Interviews with health care assistants (HCA) confirmed new HCAs are paired with a senior HCA for shifts or until they demonstrate competency on a number of tasks including personal cares for residents. Health care assistants confirmed their roles in supporting and buddying new staff. Completed orientations were not sighted in some staff files reviewed.</p> <p>Competency assessment questionnaires for relevant competencies required for specific positions, such as: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; restraint; nebuliser; blood sugar and insulin; and assisting residents to shower were sighted in staff education files reviewed.</p> <p>There were nine RNs, including the CM, that were interRAI competent.</p> <p>The organisation has a mandatory education and training programmes with annual training days provided, however, not all staff have attended the annual mandatory study days.</p> <p>The residents who are receiving rest home care and hospital level care in ORA units have their needs met within the environment in which they live.</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>Staffing levels meet contractual requirements. The BCM and the CM are RNs who are available during weekdays and on call after hours and weekends. Adequate on-site RN cover is provided 24 hours a day, 7 days a week. Registered nurses are supported by sufficient numbers of HCAs.</p> <p>There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Rosters are completed an electronic system by the receptionist and overseen by the BCM. Rosters sighted reflected that staffing levels meet resident acuity and bed occupancy.</p> <p>Residents and families reported staff provide them with adequate care. Care staff reported there are adequate staff available and that they are able to get through their work.</p> <p>The ORA units are located within the facility in close proximity to the RN office. The residents</p>



		<p>who are receiving rest home care and hospital level care in ORA units have their needs met within the environment in which they live with 24 hour care, and sufficient staffing and availability of RNs to meet their needs in accordance with the aged related residential care agreement.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of residents' records. Files, relevant resident care, and support information could be accessed in a timely manner. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>Residents' files are maintained securely. Electronic data is password protected and can only be accessed by designated staff. Archived material is also kept securely and easily retrievable.</p> <p>All components of the residents' records reviewed include the resident's unique identifier. The clinical records reviewed are integrated, including information such as medical notes, assessment information, and reports from other health professionals. Entries are legible, dated and signed by the HCA, RN or other health professional, and include their designation. Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals (refer to 1.3.3.3).</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Needs Assessment and Service Coordination (NASC) assessments are completed for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. There is an information pack provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service processes which ensured compliance with entry criteria. Interviews with residents and families and review of records confirmed the admission process was completed by staff in a timely manner. Residents and family members interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and coordinated manner.</p> <p>Interviews with RNs and review of resident files confirmed there is open communication</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>between services, the resident, and the family. All relevant information is documented and communicated to the receiving health provider or service via the yellow envelope system. A transfer form accompanies residents to receiving facilities. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and processes that describe medication management that align with accepted guidelines. Medicines are delivered in a pre-packed delivery system. Medications are checked against the resident's medication profile on arrival from the pharmacy by a RN.</p> <p>Review of the 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.</p> <p>A computerised medication management system is used at the facility and meets the current legislative requirements and safe practice guidelines.</p> <p>The medication rounds observed during lunch evidenced compliance with legislation and safe practice guidelines. Administration records are maintained, as are specimen signatures. Interviews with RNs confirmed there are no standing orders at time of audit. All staff authorised to administer medicines had current competencies. Staff education in medicine management is provided. The RNs had completed current syringe driver competency and education.</p> <p>The medication refrigerator temperatures monitored and recorded weekly are within the recommended range.</p> <p>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 by the GP. Three-monthly competency assessments were recorded for three residents self-administering their medication.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food is prepared onsite in a large commercial kitchen. The chef is responsible for the food services and is supported by two cooks and kitchen assistants. Two cooks cover the chef's days off and any planned leave or study leave. The food service is in line with recognised nutritional guidelines for older people. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration is</p>

		<p>displayed. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan.</p> <p>The kitchen cleaning schedules and equipment is maintained. Kitchen staff complete an orientation and relevant food safety training (refer to 1.2.7.4 and 1.2.7.5).</p> <p>Food in the chiller was covered and dated. The kitchen was clean and all food was stored off the floor.</p> <p>There is a four weekly seasonal menu approved by a dietitian at organisational level. Diets are modified as required. At interview, the chef reported the RN completes each resident's nutritional profile on admission with the aid of the resident and family. The kitchen is made aware of any changes. Special diets are catered for and documented in the kitchen. Special equipment, to meet residents' nutritional needs, is readily available. Meals are plated in the kitchen and delivered to the main dining room via bain-marie in each of the three areas. Food temperatures are monitored. Residents requiring extra support to eat and drink are assisted, this was observed during lunch.</p> <p>Food audits are carried out as per the yearly audit schedule by the chef (refer to 1.2.3.6). Emergency supplies are kept (refer to 1.4.7.1).</p> <p>The service encourages residents to express their likes and dislikes. The residents interviewed stated that staff ask them about their food preferences and they complete surveys which include comments about the food service (refer to 1.2.3.6).</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The service has a process in place where access is declined, should this occur. When residents are declined access to the service, residents and their family, the referring agency, general practitioner (GP) and/or nurse practitioner (NP) are informed of the decline to entry. The resident would be declined entry if not within the scope of the service or if a bed was not available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial nursing assessment and the initial care plan is completed within 24 hours of admission. Assessments are recorded, reflecting data from a range of sources, including: the resident; family; GP/NP; and specialists as applicable. Review of wound care documentation evidenced all wounds including skin tears are recorded on short-term care plans. Resident assessments inform PCCPs. Policies and protocols are in place to ensure continuity of service delivery. Assessment tools are reviewed at least six monthly including but not limited to: falls;</p>

		<p>dietary; continence; and pain. Residents interviewed confirmed assessments are conducted according to their needs and in a private manner.</p> <p>Interviews with residents and families confirmed their involvement in the assessments, care planning, review, treatment, and evaluation of residents' care.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Person centred care plans are developed with the resident and family/whānau involvement included where appropriate. Short-term care plans are developed for the management of acute problems when required, and signed off by the RN when problems are resolved. All files sampled had an individualised PCCP that covered all areas of identified needs. The care plans evidenced service integration with progress notes, activities notes, and medical and allied health professionals' notations.</p> <p>Interviews with residents confirmed they have input into their care planning and review, and that the care provided meets their needs.</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>	FA	<p>Review of residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes, and goals of residents. General practitioner documentation and records were current. Interviews with residents and families confirmed that the current care and treatment needs were being met. The service maintains family communication records in the residents' files.</p> <p>Staff interviews confirmed they are familiar with the needs of the residents they are allocated to.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The facility provides an activities programme which reflects the residents' goals, ordinary patterns of life, and includes community activities. Review of files evidenced residents' social history and their preferred activities are identified on admission. The activities coordinator plans a monthly programme with oversight by a diversional therapist, which is then made available to all residents and their families.</p> <p>Residents are free to choose whether they wish to participate in the group activities. Residents' participation in a daily exercise programme was evidenced on audit days. Residents are encouraged to maintain links with the community through outings with family and van outings organised by the activities coordinator. Birthdays and other special days are celebrated. Residents who prefer to stay in their room can have one-on-one visits including,</p>

		<p>for example, reading, hand massage and music.</p> <p>Residents' attendance and participation is documented. Outcomes against goals are recorded. Evaluations are completed six monthly with nursing review and there is evidence of resident and family participation. Resident meetings are conducted bi-monthly and include discussion around activities.</p> <p>The residents and their families reported satisfaction with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes (refer to 1.3.3.3). When changes are noted it is reported to the RN.</p> <p>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. Where progress is different from expected, the service develops a short-term care plan for the management of short-term concerns/acute problems, for example: infections, wounds, and falls. Short-term care plans, including wound care plans, are reviewed as indicated by the degree of risk noted during the assessment process (refer to 1.3.3.3).</p> <p>Interviews with residents and families confirmed they are included and kept up to date with any changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. If the need for other non-urgent services are indicated or requested, the GP, RN, or BCM sends a referral to seek specialist service provider assistance from the DHB. Referral forms and documentation are maintained on resident files. Referrals are followed up on a regular basis by RN, BCM or the GP.</p> <p>The family/whānau communication records reviewed in the residents' files, confirmed family are kept informed of the referral process.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous</p>	FA	<p>There are policies and procedures in place for the management of waste and hazardous substances. There has been a change in the supplier of chemicals and the new supplier has conducted staff training and education in the use of the new system. Material safety data sheets were available and accessible for staff. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p>

<p>substances, generated during service delivery.</p>		<p>Protective clothing and equipment appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed.</p> <p>There is a preventative and reactive maintenance programme in place. Staff are aware of the processes of reactive maintenance requests to ensure timely repairs are conducted, confirmed at staff and maintenance interviews. The maintenance staff member is supported in their role by the regional maintenance manager who was present at the audit.</p> <p>Visual observation evidenced the facility and equipment are maintained to an adequate standard, documentation reviewed and staff interviews confirmed this. The testing and tagging of equipment and calibration of biomedical equipment is current.</p> <p>The external areas are safely maintained and are appropriate to the resident group and setting. Residents are protected from risks associated with being outside. The gardens are contracted out, maintained, and provide visual enjoyment for residents, staff, and visitors.</p> <p>Staff interviews confirmed they have appropriate equipment to meet residents' needs. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs. The facility has a van that can carry 10 people that is used for residents' outings and this has a current registration.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Bedrooms throughout the facility have a toilet and hand basin or full ensuites. There is one bedroom with a handbasin. Interview with the resident residing in this room confirmed they are satisfied with their accommodation and use of communal bathroom facilities.</p> <p>There are adequate number of communal toilets and bathrooms of an appropriate design for residents. Separate toilets are available for staff and visitors. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Communal toilets and showers have a system that indicates if it they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</p> <p>Hot water temperatures are monitored monthly. When there have been hot water temperatures above the recommended safe temperature, action is taken and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	Residents' bedrooms are personalised to varying degrees. The bedrooms are single occupancy rooms. Bedrooms are large enough to allow staff and equipment to move around safely and provide personal space for residents.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There is adequate access to lounges, dining areas and sitting areas/alcoves. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not wish to participate in them.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry policies and procedures are available. Linen and residents' personal clothes are washed off site at another Oceania facility. Interview with the laundry staff member confirmed residents' personal clothes, such as woollen clothes are washed on site. There is a dirty to clean flow provided in the laundry. The laundry person described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.</p> <p>The cleaner described the cleaning processes and the use of chemicals for cleaning purposes. There are safe and secure storage areas for cleaning equipment and chemicals and staff have access to these areas as required. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility with alcohol gels in various locations.</p> <p>Residents and family satisfaction surveys have not been collated in 2017 and not completed when planned in February 2018 to ascertain satisfaction with the laundry and cleaning services. The effectiveness of the cleaning and laundry services is audited via the internal audit programme (refer to 1.2.3.6).</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and</p>	PA Moderate	Documented systems are in place for essential, emergency and security services. The fire evacuation scheme for the facility has been approved by the New Zealand Fire Services. The trial fire evacuations are conducted six monthly. The last fire evacuation education was conducted in September 2018 and fire drill was conducted in April 2018. The staff training register evidences not all staff have completed first aid training, fire evacuation education or

<p>security situations.</p>		<p>attended a fire drill.</p> <p>There is emergency lighting, gas for cooking, emergency water supply, blankets and cell phones available in case of emergency. Emergency equipment accessibility, storage, and stock availability to a level appropriate to the service setting requires review.</p> <p>The call bell system in place is used by the residents, and/or staff and family to summon assistance if required and is appropriate to the resident groups and settings. Call bells are accessible/within reach and are available in resident areas.</p> <p>Staff interviews confirmed security systems are in place and staff are aware of security processes. There are four entrances (driveways) to the facility and three of the four entrances are closed at night.</p> <p>The safety of the rest home and hospital residents residing in ORA units are the same as for the residents under other contracts.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Residents are provided with adequate natural light and safe ventilation. Residents and families confirmed the facility is maintained at a safe and comfortable temperature.</p> <p>An area outside the building is available for both residents and staff who smoke.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>FA</p>	<p>The Oaks provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. The relieving CM is the infection control nurse (ICN) and has access to external specialist advice from GPs, district health board infection control specialists, and microbiologists when required. A documented role description for the ICN, including role and responsibilities, is in place.</p> <p>The infection control programme is appropriate for the size and complexity of the service. It is reviewed annually. Staff are made aware of new infections through daily handovers on each shift, progress notes and short-term care plans. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p>



<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN is responsible for implementing the infection control programme. The ICN indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Oceania has documented policies and procedures in place that reflect current best practice relating to infection prevention and control. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and are able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Staff education on infection prevention and control is provided by the ICN and external infection control specialists. It is a mandatory requirement for all staff. A record of attendance is maintained (refer to 1.2.7.5). External contact resources include: GP; laboratories; and local district health board staff. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</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>	FA	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, analysed, monitored and reviewed monthly. Any significant trends or common possible causative factors are identified and action plans are instigated. Staff interviewed reported they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required timeframe when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, confirmed at GP interviews. There is an antimicrobial policy.</p> <p>The Oceania support office conducts benchmarking in infection prevention and control with other Oceania facilities and this is shared with management and staff.</p> <p>The ICN interviewed confirmed there had been one outbreak since the previous audit. There</p>

		was evidence this was reported to the required authority and managed according to policy and outbreak guidelines.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>The definition of restraint and enabler are congruent with the definitions in the restraint minimisation and safe practice standard. The approval process for an enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, as confirmed at staff and management interviews. Evidence of family/whānau/enduring power of attorney (EPOA) involvement in the decision making, as is required by the organisation's policies and procedure was on file in each case.</p> <p>The restraint register and enabler register is maintained. There were four enablers in use and three restraints in use on audit days that were accounted for in the form of bed rails and one lap-belt (see 2.2.2.1).</p>
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	<p>The Oceania clinical and quality team are responsible for approving any form or type of restraint practice used at Oceania facilities nationally.</p> <p>Oversight of restraint use at each individual Oceania facility is the responsibility of the restraint coordinator. The restraint coordinator at The Oaks is the relieving CM. The responsibilities for this role are defined in the position description. The restraint coordinator had completed training in restraint minimisation and restraint management relevant to their role.</p> <p>Restraints are authorised following assessment of the resident. The approval includes consultation with other members of the multidisciplinary team. The restraint consent forms evidenced consent for restraint is obtained from the GP, restraint coordinator, and the resident and/or a family member.</p> <p>Interviews with staff and staff records confirmed that restraint minimisation and safe practice, enabler usage, and prevention and/or de-escalation education training is provided.</p>
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	PA Low	<p>Assessments for the use of restraint were documented. The initial assessment is undertaken by the RN with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The GP interviewed confirmed involvement in the final decision on the safety of the use of restraint.</p> <p>The assessment process identified the underlying aetiology, history of restraint use, cultural</p>

		consideration and associated risks. Completed assessments were sighted in the records of residents who were using a restraint. Review of assessments and PCCPs evidenced possible alternatives were not always documented. On the facility tour it was observed not all bedrails in use had covers.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The use of restraints is actively minimised and the restraint coordinator described the alternatives to restraints are discussed with staff and family/whānau members.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe as verified in the resident's PCCP and monitoring forms. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month, and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint.</p> <p>Staff interviewed understood the use of restraints is to be minimised and how to maintain safe use was confirmed.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Evaluation of restraint use occurs through restraint event reporting by the facility to the Oceania support office as a clinical key performance indicator. The Oceania support office maintains records of restraint use and analysis is conducted monthly. Each individual episode of restraint is evaluated. The clinical files of residents using restraint evidenced the restraint evaluation forms are completed. These forms include all the relevant factors in this standard.</p> <p>The restraint minimisation team meeting minutes evidenced evaluation of each restraint used at the facility.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	<p>There is evidence of monitoring and quality review of the use of restraints at the facility. The restraint minimisation team meeting minutes evidenced review of the compliance with the standard. The meeting minutes include: individual resident's restraint review; restraint register update; education review; and any relevant restraint issues.</p> <p>Oceania national restraint authority group terms of reference are recorded. This group meet annually to review the compliance with the restraint standard and review of restraint use nationally.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>Review of the 2017 complaints register evidenced there were three complaints recorded in 2017. The records relating to the 2017 complaints evidenced one of the three complaints was not documented as closed out. There was documentation relating to a fourth complaint that was not entered into the complaints register. The complaints were the responsibility of the previous BCM with the CM entering this data on the Oceania intranet.</p> <p>There were no complaints recorded on the complaints register from September 2017 to March 2018. The BCM (appointed in March 2018) has been allocated responsibility to manage complaints. Review of all the complaints</p>	<p>The complaints management processes do not follow the Right 10 of the Code.</p>	<p>Provide evidence the complaints processes adhere to the Right 10 of the Code.</p> <p>90 days</p>

		<p>in 2018 was conducted and evidenced the processes required under the Right 10 of the Code have not been consistently followed. There were 13 complaints recorded on the complaints register from March to September 2018.</p> <p>In March 2018, five residents completed individual complaint forms that related to the food service at the facility (food quality, quantity and unclean utensils). There is no recorded evidence of individual verbal communications with the complainants or letters of acknowledgements within the required five days of receiving the complaints. These written complaints were acknowledged by the BCM at a residents' meeting in April 2018. Meeting minutes confirmed this. The food service has undergone review, however, there is no documented evidence of individual communication with the complainants and close out of the complaints to the residents' satisfaction.</p> <p>The review of the investigations and actions relating to individual complaints did not always have the details of the investigations and actions documented. The close out of the complaints did not consistently evidence the complainants' satisfaction with the investigation and the actions taken.</p>		
Criterion 1.2.3.6	PA Low	Oceania's schedule of internal audits are provided by the Oceania support	i) Internal audits are not	Provide evidence quality improvement

<p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>		<p>office and they are to be implemented using the Oceania audit tools. Review of the internal audit schedule evidenced the internal audits were not always completed according to the schedule. There was no documented evidence that internal audits were carried out in January, February, and March 2018. Some audits are conducted by the staff who provide the services, such as laundry staff completed laundry audits and kitchen staff completed kitchen audits.</p> <p>The family and resident satisfaction survey conducted in September 2017 does not evidence documentation of analysis and evaluations. The February 2018 resident survey had not been carried out as recorded on the schedule. A one off food services survey was initiated by the BCM in April 2018 as a result of a number of residents' complaints about the food service, however, there is no evidence of collation, analysis and evaluation or communication to the residents that participated in this survey.</p>	<p>being completed according to the internal audit schedule by an appropriate staff member.</p> <p>ii) The resident and family satisfaction survey and food survey have not been collated and analysed and communicated to appropriate personnel.</p>	<p>data is collected, analysed and evaluated and communicated to appropriate personnel.</p> <p>180 days</p>
<p>Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Low</p>	<p>The requirements for corrective action plans and their implementation, where deficiencies have been identified, are understood by management.</p> <p>The areas identified as requiring corrective actions following internal audit completion and satisfaction surveys do not always evidence a</p>	<p>Corrective actions are not always documented and implemented where an area of deficit has been</p>	<p>Provide evidence corrective action plans are documented and implemented.</p> <p>180 days</p>

		documented corrective action plan. Where corrective actions are developed, there is not always evidence of who is responsible for the actions, timeframes for completion and whether the actions have been reviewed.	identified.	
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>There is an orientation process in place for care staff. Review staff files evidenced 3 of 10 did not have recorded evidence of orientation. This included the new BCM's file which did not have documented evidence they had completed an orientation to Oceania processes and specific orientation to their position.</p> <p>Review of the chef's file (employed in May 2018) evidenced a generic orientation to kitchen services, however, the orientation was not signed off by management and there was no specific orientation to this position. The BCM stated the chef completed external orientation to the position at another Oceania facility, however, there is no documented evidence of this.</p>	Not all staff files reviewed had documentation of completion of their orientation.	<p>Provide evidence all staff complete an orientation programme.</p> <p>180 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	Oceania provide mandatory study days for all staff. There is full day study day for clinical staff, such as HCAs and RNs, and half day study days for non-clinical staff. Review of the staff training register evidenced that six staff had not completed the annual mandatory study	<p>i) Not all staff have completed the mandatory annual training and education.</p> <p>ii)</p>	Provide evidence all staff complete mandatory training and annual performance reviews are completed.



		<p>days.</p> <p>Review of staff files evidenced 2 of the 10 files did not have current performance reviews.</p>	<p>Performance reviews have not been completed for staff who require them.</p>	<p>180 days</p>
<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>	<p>PA Moderate</p>	<p>Service delivery promotes a team approach. Person centred care plans documented all interventions as assessed. For 3 rest home level residents, initial interRAI assessments and PCCPs were not completed within the 21-day timeframe.</p> <p>Short-term care plans were completed for all acute/short-term problems including, but not limited to, wounds and infections. For three short-term wounds and one long-term wound, review of wound care documentation did not document timely review as per treatment plan.</p> <p>Progress notes are maintained. Progress notes for two rest home residents did not document timely review by the RN.</p>	<p>i) Initial interRAI assessments and PCCPs were not completed within 21 days of admission.</p> <p>ii) Wound care plans do not always document timely reviews of wounds as per treatment plan.</p> <p>iii) Progress notes do not always document timely review by the RN.</p>	<p>i) Ensure all initial interRAI assessment and PCCPs are completed within required timeframes.</p> <p>ii) Ensure all wound care plans document timely review of wounds as per treatment plan.</p> <p>iii) Ensure progress notes document timely review by the RN as required by policy.</p> <p>90 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include</p>	<p>PA Moderate</p>	<p>Information in relation to emergency situations is available and displayed. Visual inspection and interviews with relevant staff confirmed the facility has</p>	<p>i) Emergency training has not been completed by</p>	<p>Provide evidence staff complete emergency training and the facility is</p>

<p>fire safety and emergency procedures.</p>		<p>three emergency cupboards stocked with emergency equipment. The RNs on each shift have access to the emergency cupboards. The inspection of all three emergency cupboards evidenced there is an equipment list of items in stock, however, this is not checked at regular intervals. There was no documented evidence of checks that the items are in working order and not expired. There were differing items in each of the emergency cupboards, with expired stock and equipment that was not working.</p> <p>Residents' registers in the emergency cupboards are replaced monthly, with out of date residents' lists in all three emergency cupboards on audit days.</p> <p>Emergency food and emergency food service equipment, such as plastic utensils are stored in a store room. Inspection of the emergency food services store room evidenced this was used for storage of other items and accessibility to the emergency food supply was restricted. The emergency food list had not been updated and there was no documented evidence this has been checked on regular basis.</p> <p>Discussions held with management in relation to emergency preparedness resulted in cleaning of the store room and preparation of emergency equipment ready for use.</p> <p>The staff training register evidenced there were five RNs that did not have current first aid training. Health care</p>	<p>relevant staff. ii) Emergency preparedness requires review.</p>	<p>prepared for an emergency.  30 days</p>
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		<p>assistants who are employed as permanent night staff require current first aid training, however, there was evidence of three HCAs who work on night shift who do not have current first aid training. Retrospective review of staff rosters evidenced there were at least two first aid trained staff per duty, including the night shift.</p> <p>Fire evacuation education was not attended by four RNs and fire drill attendance evidenced three RNs have not participated in a fire drill.</p>		
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>	PA Low	<p>Restraint assessment is completed prior to commencement of any restraint. The clinical files of residents using restraint evidenced the restraint assessment authorisation and plans were in place. Restraint assessments evidence the restraint coordinator's sign off. Five residents observed with bedrails in use at time of audit did not have any covers. Files for two of three residents with restraint did not evidence possible alternative strategies were discussed or documented.</p>	<p>i) Restraint assessments and PCCPs did not always document possible alternatives to restraint.</p> <p>ii) Not all residents observed with bedrails at time of audit had bedrail covers in place to reduce the risk of injury.</p>	<p>i) Ensure all possible alternatives/strategies discussed are documented for all residents with restraint.</p> <p>ii) Ensure all bedrails have covers to reduce risk of injury for the resident.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.