

Oceania Care Company Limited - Duart 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:	Duart Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 January 2019 End date: 9 January 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	63

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

Duart Rest Home is part of Oceania Healthcare Limited. The facility can provide services for up to 66 residents requiring rest home or hospital level of care. There were 63 residents at that facility on the first day of the audit.

This certification audit was conducted against the Health and Disability Service Standards and the facility'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.

There are two areas identified as requiring improvement relating to complaints management and the activities.

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.		Some standards applicable to this service partially attained and of low risk.
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Information regarding the Health and Disability Commissioners' Consumers' Rights (the Code); the complaints process; and the Health and Disability Advocacy Service is made available to residents and their families on admission and is accessible to residents and their families in the facility.

Staff interviews demonstrate an understanding of residents' rights and obligations. Residents and family members confirmed their rights are being met; staff are respectful of their needs and that communication is appropriate.

Residents' cultural and spiritual beliefs are identified on admission and there is access to cultural and spiritual support if required. Informed consent is practised and written consent is obtained 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.

Staff communicate with residents and family members following any incident and this is recorded in the resident's file. Residents, family and GP interviews confirmed that the environment is conducive to communication, issues are identified where applicable, and that staff are respectful of residents' needs.

There is a documented complaints management system that aligns with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Complaints are investigated and documented, with corrective actions implemented where required. A complaints register is maintained. There have been no complaints to external agencies since the last audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Oceania Healthcare Limited is the governing body responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned.

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement meetings at the facility. Facility meetings are held and include reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

The facility has an incident and accident management system to record and report adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting.

The business and care manager provides operational oversight of the service. The clinical manager is a registered nurse and is responsible for clinical management and oversight of services and is supported by the regional clinical quality manager.

Human resource policies and procedures guide practice and there is evidence that human resource processes are being followed. 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. Staffing levels are adequate across the services.

Systems are in place to ensure the consumer information management system is protected from unauthorised access.

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 low risk.
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Safe and appropriate access to the service is provided through the Needs Assessment Coordination Service.

Residents' needs are assessed on admission by a registered nurse using the initial nursing risk assessments for data collection to create initial care plans. The interRAI assessment is completed to inform the person centred care plan, which is completed over three weeks after admission to the service. Person centred care plans indicate progress towards meeting the residents' desired outcomes. Nursing care plan evaluations are documented and resident-focused. Where the progress of a resident is different from expected, a short-term care plan is completed. The residents and/or their families have the opportunity to participate and contribute to care planning and evaluation of care.

Planned activities are managed by a diversional therapist and an activities assistant. Activities are appropriate to the aged residential care residents and interviews with older people and their families confirmed their satisfaction with the activities programme.

There is a medicine management system in place to ensure safe and appropriate processes for prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation. Staff responsible for medicine management have current competencies completed annually and attend medication management training and education. There were no residents self-administering medicines.

Menus meet national nutritional guidelines for older people. The service is using the template food plan approved in September 2018. Residents' special dietary requirements and needs for assistance during feeding are met. Residents verified their satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness and an approved fire evacuation plan.


A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes equipment and electrical checks.

Residents' rooms provide single accommodation and are of an appropriate size to allow for care to be provided and the safe use and manoeuvring of mobility aids. Bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has a monitored call bell systems for residents to summon help, when needed, in a timely manner.

There are documented and implemented policies and procedures for cleaning and waste management. Cleaning services are provided seven days a week by household staff and monitored. The laundry service is outsourced.

Essential security systems are in place to ensure resident safety. Six monthly trial evacuations are undertaken.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Oceania policies and procedures for restraint minimisation and safe practice are used to guide restraint management. The policies are aligned with the requirements of the standard. There are systems in place to ensure safe management of restraint and where requested, enabler use.

Staff complete annual education and training on restraint and enabler management processes. At the time of the on-site visit, there were two restraints and three enablers being used by residents.

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 infection prevention and control policies and procedures include guidelines on the prevention and minimisation of infection. The organisation has a clearly defined and documented infection control programme that is aligned with the requirements of the standards and reviewed at least annually. Induction and orientation of new staff include training in infection control practices. The service has ongoing infection control education and training available for all staff.

The surveillance programme is appropriate for the size and complexity of the service. Infection prevention and control data is collected, collated, analysed and reported through all levels of the organisation, including governance. Infection control surveillance data is benchmarked internally against other Oceania facilities.

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	48	0	2	0	0	0
Criteria	0	99	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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	<p>There are implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>All staff have received education on the Code as part of orientation and the annual education programme. Staff interviews confirmed their understanding of the Code and their obligations. Evidence that the Code is implemented in their everyday practice includes but is not limited to: maintaining residents' privacy; providing residents with choices; encouraging independence; involving residents and family in decision making and ensuring residents are able to practise their own personal values and beliefs.</p> <p>Residents and family interviews and observation confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff are respectful towards residents and their families and residents receive information relevant to their needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided</p>	FA	<p>The organisation's informed consent policy provides the guidelines to ensure that all residents or their family will be informed about the management and care to be provided in order that they may arrive at a reasoned and non-pressured decision about any proposed treatment or</p>

<p>with the information they need to make informed choices and give informed consent.</p>		<p>procedure. It describes what consent involves and how it may be facilitated, obtained, refused and withdrawn. It ensures that staff members adhere to the legal and ethical requirements of informed consent and informed choice for health care services and service provision. The policy includes guidelines for consent for treatment, photographs, specific cares, collection and storage of information, and advance directives. Advance directives and resuscitation orders are completed for residents when applicable.</p> <p>The information pack provided on/prior to admission includes information regarding informed consent. The CM or registered nurse (RN) discusses this with residents and their families during the admission process to ensure understanding. Staff receive training in the informed consent process and staff interviews confirmed they are aware of the informed consent process.</p> <p>There is an advanced directives and an end of life decision policy to ensure that appropriate ethical concepts are upheld in resident treatment and care situations in relation to end of life. The policy defines the procedure for obtaining an advance directive and who may or may not make an advance directive. File reviews demonstrated that advance directives were completed in accordance with policy.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There is an advocacy policy and procedure for staff to follow to ensure that residents and their families have a right to be represented and express views or concerns about their situation. It includes making them aware of the availability of advocacy services and support access to advocacy services. Information regarding the availability of the Nationwide Health and Disability Advocacy Service is provided in the information packs provided to residents and family prior to and on their admission to the facility. Additional advocacy services brochures are also available at the entrance to the residents' dining room. The complaints policy also includes making residents aware of their right to advocacy when making a complaint.</p> <p>An interview with the manager confirmed that advocacy services can also be accessed on behalf of residents externally, for example, through Age Concern and through the local hospice for palliative care residents.</p> <p>Family and resident interviews confirmed that the facility provides opportunities for the family to be involved in decisions, they are aware of the right to advocacy and the advocacy services available.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community</p>	<p>FA</p>	<p>Observations and resident and staff interviews confirmed that residents may have access to visitors of their choice at any time. There are areas where a resident and family can meet in</p>

<p>Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>		<p>private. Observations and interviews confirmed that families were made to feel welcome in the facility.</p> <p>Interviews confirmed that residents are able to maintain existing community involvement with family and social networks. Resident interviews confirmed that residents are free to leave the facility when they so choose, for example, to attend appointments and family outings. The activities programme and the content of care plans include regular outings in the community (refer to 1.3.7.1) .</p> <p>Young people with disabilities (YPD) are able to access to activities and resources in the community as well as family and networks if they so choose (refer to 1.3.7.1).</p> <p>There is facility for residents who are able, to store, charge and continue to use their mobility scooters in order to be mobile in the community and surrounding areas.</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>	<p>PA Low</p>	<p>The organisation's complaints policy outlines the complaints procedure that is in line with the Code and includes the expected timeframes for responding to a complaint. The complaint process and forms are made available as part of the admission pack. The complaint forms are also available at the entrance to the facility.</p> <p>The BCM is responsible for managing complaints. An up to date complaints register is in place that includes: the date the complaint is received; the source of the complaint; a description of the complaint; resolution and the date the complaint is signed off. Evidence relating to each lodged complaint is held in the complaints folder and register. Complaints reviewed indicated that complaints are investigated promptly and issues are resolved in a timely manner. However, verbal concerns/complaints were not consistently documented and actioned.</p> <p>Staff interviews confirmed that residents and family were encouraged to raise any concerns and provide feedback on services. Residents and family interviews confirmed that they were aware of the complaints process. With the exception of one interview, residents stated that any issues raised are dealt with effectively and efficiently. Residents and family interviews confirmed an understanding of their rights to advocacy and how to access advocacy services in relation to the complaints process.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During</p>	<p>FA</p>	<p>New residents and their families are provided with information about the Code as part of an</p>

<p>Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>information pack provided on admission to the facility. The clinical manager (CM) also explains the Code to ensure understanding during the admission process. The pack includes information on the complaints process and advocacy service.</p> <p>The Code and associated information is also available in information brochures which are displayed at the entry to the facility and available to take away and read in private. Information on the Code is also displayed in posters in English and te reo Māori.</p> <p>Advocacy services can be accessed externally for residents if required.</p> <p>Residents and family members interviewed were familiar with the Code and the advocacy service.</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>	<p>FA</p>	<p>The organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code and ensure that a resident's right to privacy and dignity is upheld.</p> <p>Interviews and observation confirmed that staff knock on bedroom and bathroom doors prior to entering rooms and ensure that doors were shut when personal cares were being provided. Interviews and observation confirmed that conversations of a private nature were held in the resident's room and not in public areas. Residents and families stated that they felt that resident privacy is respected.</p> <p>The organisation has a policy on sexuality and intimacy to ensure that staff understand to respond adequately to a resident's expressions of sexuality. It includes: identifying resident needs; and responding to expressions of sexuality.</p> <p>Resident files, interviews and satisfaction surveys confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented, and upheld.</p> <p>There are policy and guidelines for staff on abuse and neglect prevention and management. Staff receive orientation and annual training on abuse and neglect. Staff interviews identified staff are aware of their obligations to report any incidences of suspected abuse. There were no documented incidents of abuse or neglect. Staff, resident, and family interviews confirmed that there was no evidence of abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p>	<p>FA</p>	<p>The organisation has a Māori health plan/policy that demonstrates Oceania Healthcare Limited's commitment to respecting the cultural, values and beliefs of residents identifying as Māori and acknowledges the Treaty of Waitangi. There is also a cultural competent services policy that</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>		<p>describes for staff how culturally competent services should be delivered.</p> <p>Support for staff in providing culturally appropriate care, and for Māori residents and their families, can be sourced if required through the DHB and linkages with local kaumātua. Staff receive training in cultural safety and values, and Māori health at orientation as well as part of the mandatory annual education programme. There was one resident identifying as Māori at the time of audit.</p> <p>Staff interviews confirmed awareness of how culturally competent services would be delivered and were aware of the importance of the involvement of immediate and wider whānau in the delivery of care for any Māori residents. This includes making available a room to accommodate extended whānau when required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family are involved in the assessment and the care planning processes.</p> <p>Information gathered during assessments includes identifying a resident's specific cultural needs, spiritual values, and beliefs. A review of residents' files confirmed that specific cultural needs identified in assessments are reflected in the residents' care plans. Assessments also include obtaining background information on a resident's spiritual and cultural preferences, which includes but is not limited to: beliefs; cultural identity; and church attendances. This information informs activities that are tailored to meet identified needs and preferences (refer to 1.3.7.1).</p> <p>Weekly church services are held in different denominations for residents who chose to attend a service and the opportunity to receive communion is available.</p> <p>Resident interviews and surveys confirmed that the services were responsive to individual resident's cultural needs.</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>There is a policy to ensure the environment for residents is free from discrimination; coercion; harassment; and financial exploitation. The policy describes for staff how this will be prevented and, where suspected, reported.</p> <p>Job descriptions include the responsibilities of the position, including ethical issues relevant to each role. Staff interviews confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation</p>

		<p>There were no complaints or incidents recorded since the previous audit relating to any form of discrimination, coercion or harassment. There was one instance of exploitation and essential reporting procedures were followed. This was confirmed in staff, resident and family interviews.</p> <p>Staff mandatory training includes professional boundaries. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Resident and family interviews confirmed that staff maintain appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The facility implements the Oceania Healthcare Limited (Oceania) policies and procedures which are current and based on good practice and current legislation and guidelines. The policies align with the Health and Disability Services Standards and ensure safe, current evidence based practice.</p> <p>There are relevant training programmes for all staff. Benchmarking occurs across all the Oceania facilities. Results of benchmarking is made available to staff on staff notice boards and through monthly meetings.</p> <p>Staff, resident and family interviews, residents' file notes and observation of service delivery confirmed that resident care was based on good practice guidelines.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy that sets out the process to guide staff to ensure there is open disclosure of any adverse event where a resident has suffered any unintended harm while receiving care. Completed incident forms and residents' records demonstrated that family are informed if the resident has an incident/accident; a change in health or a change in needs. Family contact is recorded in residents' files and on incident forms.</p> <p>Family and resident interviews confirmed that family are informed of any changes in resident status and that they are invited to the care planning meetings for the resident. Family are invited, via email to attend upcoming residents' meetings. Two monthly residents' meetings inform residents of facility activities and provide an opportunity to raise and discuss issues/concerns with management (refer to 1.1.13.1). Minutes of the residents' meetings sighted provided evidence that a wide range of subjects are discussed. Residents have access to the minutes from these meetings and are also provided with copies of the activities planned and the menu.</p> <p>Residents and staff are also informed of updates and events through the monthly newsletter, which provides updates from staff, new team members, upcoming events and puzzles. Interviews confirmed that the business and care manager (BCM) and staff made themselves</p>

		<p>available to discuss services and issues with residents and their families.</p> <p>There is policy that provides guidance and procedures for staff to ensure that residents who do not use English as their first language are offered interpreting services. It states that staff have access to a list of interpreting services and family may only interpret with a resident's consent. Interviews confirmed that interpreter services would be accessed through the DHB or the International Culture Society, if required. At the time of the audit there were no residents who required an interpreter.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The facility is part of the Oceania Group with the executive management team providing support to the facility. Communication between the service and Oceania executive management occurs monthly with the clinical and quality manager providing support during the audit. The monthly facility business status report provides the executive management with progress against identified indicators.</p> <p>Oceania has a documented mission statement, values and goals. These are displayed on the wall in the main hallway and also communicated to residents, staff and family on the internet and in staff training.</p> <p>In addition to the overarching Oceania business plan, the facility has a business plan and a quality improvement plan specific to Duart Rest Home that sets out the future direction and improvements for the facility.</p> <p>The facility is managed by a BCM who is supported by a CM. The BCM has been in this position for five months and has previous experience as a paramedic (overseas) and in business management. The clinical care at the facility is overseen by the CM. The CM is a registered nurse (RN) who has been employed by Oceania for five years and has previous experience as a RN and a team leader in another aged residential care (ARC) facility. The CM has been in this position for two years. The management team is supported in their roles by the Oceania executive and regional teams and have completed induction and orientation appropriate to their respective roles.</p> <p>The facility is certified to provide rest home and hospital level care and currently provides care for up to 66 residents with 63 beds occupied at the time of the audit. Occupancy included 34 residents requiring rest home level care and 25 requiring hospital level care. In addition there was one resident, assessed at hospital level care and one resident (aged over 65) assessed at rest home level care under a younger persons with a disability (YPD) agreement. There were also two residents under the mental health agreement; one assessed at hospital level care (aged under 65) and one assessed at rest home level care. The facility has contracts with the</p>

		DHB for the provision of rest home and hospital level care; palliative care; restore in ARC (short-term stay); mental health in ARC; and residential non-aged care (YPD services).
<p>Standard 1.2.2: Service Management</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>	FA	<p>During a temporary absence of the BCM, the CM is responsible for the day to day operation of the service and is supported by experienced RNs, the regional clinical and quality manager, and the regional operations manager.</p> <p>In the absence of the CM, RNs with the support and help of the regional clinical and quality manager, ensure continuity of clinical services.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The facility utilises Oceania's documented quality and risk management framework that is available to staff to guide service delivery.</p> <p>All policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies are presented to staff at staff meetings and on the staff noticeboard. Policy updates are also provided as a part of relevant in-service education. Staff confirmed that they are advised of new and updated policies.</p> <p>The service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators such as: complaints; incidents and accidents; surveillance of infections; pressure injuries; falls; medication errors and implementation of an internal audit programme.</p> <p>There is evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data provides evidence that data is being collected and collated with the identification of trends and analysis of data. Where required, corrective action plans are developed, implemented, evaluated and closed out. There is communication with staff of any subsequent changes to procedures and practice through meetings and staff notices.</p> <p>Residents and family are notified of updates through the facility's resident meetings. Quality, health and safety and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. Staff reported that they are kept informed of quality improvements. Copies of meeting minutes are available for review in the staff room for staff that were unable to attend a meeting.</p> <p>Satisfaction surveys for residents and family are completed as part of the internal audit programme. The December 2018 surveys reviewed evidenced satisfaction with services</p>

		<p>provided and this was confirmed by resident and family interviews (refer to 1.1.13.1).</p> <p>The organisation has a risk management programme in place that records management of risks in clinical, environment, human resources and other areas specific to the facility. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly.</p> <p>There is a nominated health and safety representative and a clear understanding of the obligations of the role was confirmed by interview. There is evidence of hazard identification forms being completed when a hazard is identified and that hazards are addressed and risks minimised. A current hazard register is available and is reviewed and updated annually or upon identification of a new hazard.</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>Policy and procedures reference essential notification reporting; for example, health and safety, human resources, and infection control. The BCM is aware of situations which require the facility to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles. These are reported to the appropriate authority by the Oceania support office and there is evidence of correct and accurate reporting. There had been two events requiring essential notifications to external agencies since the last audit. These included a police investigation of the fraudulent use of a credit card and a missing resident.</p> <p>Staff interviews confirmed that all staff are encouraged to recognise and report errors or mistakes. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events. Staff records reviewed demonstrated that staff receive education at orientation on the incident and accident reporting process.</p> <p>There is an implemented accident/incident reporting process and incident reporting forms are available throughout the facility. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on an accident/incident form which is signed off by the BCM. Incident reports selected for review evidenced the resident's family had been notified, an assessment had been conducted and observation completed. There is evidence of a corresponding note in the resident progress notes and notification of the resident's nominated next of kin where appropriate.</p> <p>Corrective actions arising from incidents were implemented. Information gathered is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data</p>

		<p>occurring with other Oceania facilities. Results of accident/incident data is benchmarked nationally with other Oceania facilities and trends are analysed. Accident/incidents are also discussed at quarterly regional cluster meetings. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared at health and safety and staff meetings.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; a signed employment agreement; position specific job description; police vetting; and identification verification. An appraisal schedule is in place and all staff files reviewed evidenced a current performance appraisal.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that require them.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks, including personal cares. Interviews confirmed that new staff are supported and buddied into their new roles.</p> <p>The organisation has implemented the Oceania documented role specific mandatory annual education and training modules. Education session attendance records evidenced that ongoing education is provided. There are systems and processes in place to ensure that all staff complete their required training and competencies. Training records evidenced that staff have undertaken a minimum of eight hours of relevant training.</p> <p>The CM and seven RNs have completed interRAI assessments training and competencies. Annual competencies are completed by care staff, for example: fire training; infection control; hoist use; restraint; medication management; and wound management.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced</p>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Rosters sighted reflected that staffing levels meet resident acuity and bed occupancy.</p> <p>Rosters are available to staff at least two weeks in advance and staffing levels are reviewed to accommodate anticipated workloads, identified numbers and appropriate skill mix, or as required</p>

<p>service providers.</p>		<p>due to changes in the services provided and the number of residents.</p> <p>There are sufficient RNs and health care assistants (HCA), available to safely maintain the rosters for the provision of care, to accommodate increases in workloads and acuity of residents such as additional hospital level residents. The main building is spread over two floors, each with two wings that accommodate a mix of rest home and hospital level residents, in addition there is an adjoining single level building that accommodates only rest home residents. Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract.</p> <p>There are 60 staff, including: the management team; administration; clinical staff; diversional therapist; activities assistant; and household staff. Household staff include cleaners who provide services seven day a week and kitchen staff. A review of rosters demonstrated that there is at least one RN on each shift. The BCM and CM are on call after hours, seven days a week.</p> <p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Residents and family interviews stated that staffing is adequate to meet the residents' needs. Staffed confirm that they have sufficient time to complete their scheduled tasks and resident cares.</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>	<p>FA</p>	<p>Residents' records are maintained in hardcopy and electronically. Residents' information, including progress notes, are legible and entered into the resident's record in an accurate and timely manner, identifying the name and designation of the person making the entry. Residents' progress notes are completed every shift, detailing resident response to service provision.</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of obligations and procedures for maintaining confidentiality of resident information. Resident care and support information can be accessed in a timely manner and when not in use is protected from unauthorised access by being locked in a cabinet in a staff office. Archived records are securely stored and easily retrievable. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the resident and/or resident's family where applicable.</p> <p>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Electronic medication charts are kept</p>

		separate from residents' files and are accessible by authorised personnel only.
<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>Processes for entry into the service at Duart Rest Home are recorded and implemented. Needs assessments are completed for residents at rest home and hospital level of care.</p> <p>Residents' files reviewed had needs assessments completed, including the interRAI assessment. Residents who are younger persons with disabilities had Needs Assessment Services Coordination (NASC) assessments on file.</p> <p>The residents' admission agreements evidenced resident and/or family signatures. The admission agreement defines the scope of the service and includes contractual requirements.</p> <p>Interviews with residents and family and review of records confirmed the admission process was completed by staff in timely manner.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer of residents are managed in a planned and coordinated manner. There is open communication between services, resident and family.</p> <p>At the time of transition, appropriate information is supplied to the service or the individual responsible for ongoing management of the resident. Referrals are documented in the residents' progress notes and copies of referrals can be found in their clinical files.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Policies document requirements for each stage of medication management. The medication management is recorded to level of detail and communicated to residents and their families in a way that complies with legislation and guidelines.</p> <p>Medication areas were reviewed during the on-site audit. The medication areas evidence appropriate and secure medicine dispensing systems, free from heat, moisture and light. Medicines are stored in original dispensed packs. The medicines registers are maintained with RNs completing weekly checks. Six monthly physical stocktakes are undertaken by the pharmacy. The medication fridge temperatures are conducted and recorded.</p> <p>Staff authorised to administer medicines have current competencies. Administration records and specimen signatures are maintained. Staff education in medicine management is provided.</p> <p>Electronic medicine charts evidenced current residents' photo identification, legibility, as required (PRN) medication is identified for individual residents and correctly prescribed. Allergies are</p>

		<p>identified when applicable. Three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. The residents' medicine charts record all residents' medication. The lunch-time medicines round was observed and seen to meet current legislative requirements and safe practice guidelines.</p> <p>The service's policies provide guidelines and processes for residents to self-administer medicines. At the time of the audit there were no residents who self-administered medicine at the facility, including YPD residents.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Registered nurses complete residents' dietary and nutritional assessments on admission. Each resident has a dietary profile developed. Personal food preferences of the residents, special diets and modified nutritional requirements are known to the kitchen manager and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, was sighted.</p> <p>Residents' files demonstrated monthly monitoring of individual resident's weight and where there was evidence of weight loss, residents' weight was monitored weekly. Residents who are identified with weight loss had completed short-term care plans with relevant interventions to monitor and manage their weight.. Residents' individual preferences are met and adequate food and fluids are provided.</p> <p>Resident satisfaction with meals was verified during interviews, sighted in satisfaction surveys and evident in resident meeting minutes. Fridge temperatures and food temperatures are monitored twice a day. Kitchen staff have attended food safety training.</p> <p>The provider has an up-to-date food template control plan, which is used throughout the Oceania group. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</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>	FA	<p>Where referral to the service is declined the risk to the individual and their family is appropriately managed. The service has a process in place to inform residents and family of the reasons why services had been declined.</p> <p>Resident and/or their family is referred to more appropriate services in the area, when access to the service is declined. Referral agencies are informed of the reasons for decline of entry. Decline of entry only occurs if the residents' needs are 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>	FA	<p>Residents' needs, outcomes and goals are identified through the assessment process and recorded in their individual record. There are processes in place to seek information from a range of sources, for example: the resident; family; GP; specialist and the referrer. Policies and protocols are in place to ensure continuity of service delivery.</p> <p>The residents' files evidenced ongoing assessments including assessments on discharge and/or transfer. The service has appropriate resources and equipment. The assessments of residents in the service are conducted in a safe and appropriate environment, usually the resident's room, including visits from the GP. Interviews with residents and families confirmed their involvement in the assessments.</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>Residents' care plans are individualised, integrated and up to date. Interventions are recorded to reflect risk assessments and the level of care required. InterRAI assessments are completed by RNs and are used to inform the PCCPs.</p> <p>Short-term care plans are developed for the management of acute problems such as; initial wounds, infections and other acute problems. Short-term care plans are closed and signed off by the RN when problems are resolved. Interviews with residents and family members confirmed they have input into the care planning and review processes.</p> <p>Clinical notes of YPD in the service, confirmed PCCPs are in place (refer to 1.3.7.1).</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>Residents' PCCPs evidence interventions based on assessed needs, desired outcomes and goals of residents. The GP documentation and records are current. Interviews with residents and families confirmed current care and treatments meet residents' needs (refer to 1.1.13.1 and 1.3.7.1).</p> <p>The service maintains family communication records in residents' files. Nursing progress notes and observation charts are maintained by staff. Handover occurs at the end and start of each shift and contributes to continuity of care for residents. Staff confirmed they are familiar with the needs of the residents who were allocated to their care.</p>
<p>Standard 1.3.7: Planned Activities</p>	PA Low	<p>Interview with the diversional therapist (DT) confirmed the activities programme meets the needs of older persons. However, the activities programme did not meet the needs of all younger</p>

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>residents. The DT and the activities assistant plan, record, implement and evaluate the activities, however, not all attendance records were up to date.</p> <p>The service has one activities programme for the rest home and hospital. The programme is in colour and printed in a large font making it easy to read for those residents who are having difficulty reading small print. The programme includes regular exercises and outings are provided for those residents able to participate. The activity programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.</p> <p>There are current, individualised activities care plans in residents' files. Residents' recreational reviews are managed through the interRAI assessment process and the PCCP is updated accordingly. Residents' meeting minutes evidenced their involvement and consultation of the planned activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated at each shift and recorded in the progress notes (refer to 1.3.13.1). Changes are noted and reported to the RN or the CM (refer to 1.1.13.1)..</p> <p>The degree of a resident's response in relation to desired outcomes following reassessment which 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.</p> <p>Short-term care plans are reviewed daily, weekly or fortnightly, as indicated by the degree of risk noted during the assessment process. Wound care plans evidenced timely reviews. Interviews verified residents and family are included and informed of changes that may occur in care, treatment and the condition of the resident.</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>	<p>FA</p>	<p>There are processes in place to provide choices to residents when accessing other services or when being referred to other health and/or disability services in the community. The family communication sheets, located in the residents' files, confirmed family involvement. Progress notes also reflect family contact.</p> <p>The service provides choices to residents through a multidisciplinary team approach and progress notes record facilitation of choices to the residents.</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 substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling and disposal of and collecting waste. The hazard register is available and current.</p> <p>Current material safety data posters are available and accessible to staff in relevant places in the facility.</p> <p>Staff receive training and education in waste management as a component of the mandatory training.</p> <p>Interviews and observations confirmed that there is sufficient personal protective clothing and equipment provided, such as aprons, gloves and masks. Interviews confirmed that the use of personal protective clothing and equipment is appropriate to the recognised risks. Observation confirmed that personal protective clothing and equipment was used in high-risk areas.</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>There is a current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation.</p> <p>There is an implemented preventative and reactive maintenance schedule. Staff interviews confirmed awareness of the processes for maintenance requests to ensure timely repairs are conducted.</p> <p>Staff interviews and visual inspection confirmed there is adequate equipment to support care, including care for residents with disabilities. The facility has an annual test and tag programme and this is up to date, with evidence of checking and calibration of biomedical equipment. There is a systems to ensure that the facility has a van that is used for residents' outings is routinely maintained. Inspection confirmed the van has a current registration and warrant of fitness.</p> <p>Hot water temperatures are monitored monthly and were noted to be maintained within recommended temperature ranges. A review of temperature assays and an interview with the maintenance person confirmed that where there have been hot water temperatures above the recommended safe temperature, action is taken and rechecking of the temperature occurs to ensure a safe temperature is maintained.</p> <p>All resident areas can be accessed with mobility aides. There are paved courtyards; landscaped lawns, and outdoor seating and shade that are able to be accessed freely by residents and their visitors. Observation and residents and family interviews confirmed that residents can move freely around the facility and that the accommodation meets their needs.</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>There are sufficient numbers of accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility. There are some rooms that have ensuite toilet facilities, however, most residents access shared toilet and bathroom facilities.</p> <p>Communal toilets have a system to indicate vacancy and have sufficient disability access. Visitor toilets are conveniently located near communal areas. All shower and toilet facilities have: call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence.</p> <p>Residents were observed being supported to access communal showers in a manner that was respectful and preserved resident dignity.</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>	<p>FA</p>	<p>Residents have their own room and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Resident interviews confirmed that there was sufficient space to accommodate: personal items; furniture; equipment; and staff as required.</p> <p>Residents and their families are able to personalise their rooms. Residents' rooms viewed were personalised with their own furniture; possessions and memorabilia.</p> <p>There are designated areas to store equipment such as mobility scooters, wheel chairs and walking frames safely and commodes tidily.</p>
<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>	<p>FA</p>	<p>There are lounge/dining rooms in each of the three main facility areas. There are also smaller lounges at in each of the facility areas with seating and a view of gardens and surrounding area. In addition there are external areas with seating and shade. All areas can be easily accessed by residents and staff. There are sufficient quiet areas for residents and their visitors to access if they wish. This include places where young people with disabilities can find privacy. Observation and residents and family interviews confirmed that residents can move freely around the facility and that the accommodation meets their needs.</p> <p>Furniture in residents' rooms: includes residents' own personal pieces; is appropriate to the setting; and is arranged in a manner that enables residents to mobilise freely. There is an activities area for storing equipment and resources and the lounge areas can be used for activities.</p>

		<p>Most residents were observed to have their meals with other residents in communal dining room, however, can choose to have their meals in their room if they wish.</p>
<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>	<p>FA</p>	<p>Laundry is undertaken off-site. This includes laundering of residents' labelled personal clothing. There are processes in place for the daily collection, transportation and delivery of linen and residents' personal clothing. There is clear delineation and observation of clean and dirty areas in the laundry area. Health care assistants are responsible for the unpacking and sorting of clean linen.</p> <p>There are cleaners on duty each day, seven days a week and cleaning duties and procedures are clearly documented, to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemicals on a trolley when cleaning and is aware of the need to keep the trolley with them at all times.</p> <p>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>The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Resident and family interviews and observation noted the facility to be clean and tidy.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Staff files and training records demonstrate that orientation and the annual training programme includes emergency and disaster procedures and fire safety. An approved fire evacuation plan was sighted. Staff interviews and documentation confirmed that fire drills are conducted at least six monthly. There is a monitored fire alarm; a sprinkler system installed throughout the facility; and exit signage displayed. The RN is the nominated fire warden for each shift.</p> <p>The staff competency register evidenced staff have current first aid certificates where required. This includes RNs; 12 HCAs; the DT; and kitchen manager. There is at least one staff member on each shift with a current first aid certificate.</p> <p>There are sufficient supplies to sustain staff and residents in an emergency situation including alternative energy and utility sources that are available in the event of the main supplies failing. These include a barbeque and gas bottles; lighting; sufficient food, water, and continence supplies. The service's emergency plan includes considerations of all levels of resident need,</p>

		<p>including YPD residents.</p> <p>There are call bells to summon assistance in all resident rooms and bathrooms. Call bells are checked monthly by the maintenance person. Observation on the days of the audit and resident and family interviews confirmed that call bells are answered promptly.</p> <p>There are security systems in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building and the facility being locked in the evenings and night time with restricted entry afterhours.</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>	FA	<p>All residents' rooms and communal areas accessed by residents have safe ventilation and sufficient external windows providing natural light. The environment in all areas was noted to be maintained at a satisfactory temperature for residents.</p> <p>There are systems in place to obtain feedback on the comfort and temperature of the environment. Resident and family interviews confirmed that the environment was maintained at a comfortable temperature and there were no issues identified with the temperature of the facility.</p> <p>There is a designated covered smoking area for residents and steps in place to ensure that smoking does not impact on other residents or staff. At the time of the audit there was one resident who smoked.</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>	FA	<p>The responsibility for infection control is clearly defined in the infection prevention and control policy. This includes the responsibilities of the organisations' national infection control committee; the infection control nurse and the infection control team. Infection prevention and control programme for Duart is reviewed annually.</p> <p>There is a signed ICN job description outlining responsibilities for this role. The ICN is the CM who is supported in the role by RNs, the GP, the clinical and quality manager, and the infection control team.</p> <p>The infection prevention and control policies and procedures manual provides information and resources to inform staff on infection prevention and control processes. The service has strategies in place to prevent exposure of infections to residents, visitors and staff.</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 has access to relevant and current information, appropriate to the size and complexity of the service.</p> <p>Infection control is an agenda item at the facility's meetings. The internal audit programme includes infection control audits to monitor the implementation of the infection control programme. The infection control committee had representatives from a variety of different disciplines such as HCAs; RNs; the kitchen manager; management; activities and house-keeping services.</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>The Oceania infection control committee develop and review the IPC policies and procedures to be implemented within their facilities.</p> <p>Policies are developed and reviewed regularly in consultation and with input from relevant staff and external specialists. The infection control manual is up to date and accessible to staff. Policies reflect current accepted good practice and reflects relevant legislative requirements.</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>Infection control education is provided to all staff, as part of their orientation and as part of the ongoing in-service education and training programme. The infection control staff education and training is provided by the ICN. The ICN has attended external education relating to infection prevention and control and also completed e-learning modules online. Education sessions for staff include records of staff attendance and participation. The content of presentations is available for review. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews.</p> <p>There is evidence that residents receive information on hand-washing techniques and how they can contribute to the prevention and control of infections. Annual infection control training for residents is provided as part of a resident meetings. Staff confirmed that clinical staff identify situations where infection control education is required for residents and that one on one infection control education of residents occurs in an informal manner.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>The ICN is responsible for the surveillance programme. Infection control surveillance occurs</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>monthly with analysis of data and reported at staff and quality meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service.</p> <p>Standardised definitions are used for the identification and classification of infections. Staff complete infection logs for all episodes of infections. Residents diagnosed with infections had a short-term care plan in place for the management of the infection.</p> <p>Interviews with staff reported they are made aware of infections through short term care plans, progress notes, handover and verbal feedback from RNs and the CM. There have been no outbreaks since the previous audit.</p> <p>The facility's surveillance data is benchmarked against other Oceania facilities and this information is shared with staff and management.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The Oceania company-wide restraint minimisation and safe practice policy complies with the standard and relevant legislation. Definitions of restraint and enablers are congruent with the standard. There were two residents at the facility using restraints and three residents using enablers during the on-site audit. The approval process for enabler use is implemented when a resident requests an enabler to assist them to maintain independence and/or safety. Enabler use is voluntary.</p> <p>Oceania support office maintain records of restraint use. National results indicated there has been a reduction in restraint used for the organisation.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	<p>FA</p>	<p>The national clinical and quality team is responsible for approving any form or type of restraint practice used throughout Oceania facilities. Oversight of restraint use at individual Oceania facility is the responsibility of restraint coordinators.</p> <p>The restraint coordinator at Duart is one of the RNs. The responsibilities for this role are defined in the position description and this was sighted during the on-site audit. The restraint coordinator has completed training in restraint minimisation and was able to describe their role relating to restraint requirements.</p> <p>Restraints are authorised following an assessment of the resident. The approval process includes consultation with other members of the multidisciplinary team. Restraint consent records reviewed included evidence that the GP, restraint coordinator and the resident and/or a family member contribute to the decision making processes.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The restraint assessment is completed prior to use of any restraint. The clinical files of residents using restraint showed that restraint assessments are completed and restraint needs are recorded in the PCCPs. Restraint assessments include identification of restraint risks and monitoring timeframes are clearly documented. Factors as listed in criterion 2.2.2.1 (a-h), required to be taken into consideration prior to the restraint decision, are discussed at each new restraint assessment.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Processes of assessment, approval, implementation, care planning, evaluation and monitoring are part of the restraint protocol to ensure safe and appropriate use of restraint. Processes are recorded in the residents' clinical files. Protocols guide staff in the safe use of restraint. Strategies for the safe use of restraint such as the use of low beds and sensor mats are implemented prior to the use of restraint. The policies that guide staff in the safe use of restraint include approved forms of restraint; associated risks; safety precautions; authorisation; reporting and monitoring requirements.</p> <p>Induction and orientation processes as well as in-service education include restraint management, enabler usage and de-escalation training. Evidence of ongoing education regarding restraint and challenging behaviours was evident. Restraint competency testing of staff is completed annually as part of their training. Health care assistants are responsible for implementing and recording restraint monitoring processes when restraints are in use and are overseen by RNs and the CM.</p> <p>The restraint register is up to date and records necessary information to provide an auditable trail of restraints.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Each individual episode of restraint is evaluated. The clinical files of residents using restraint evidenced the restraint evaluation forms are completed.</p> <p>The restraint minimisation team meeting minutes evidenced evaluation of each restraint used in the facility. Residents and the family are involved in the evaluation of the effectiveness and needs for continuing restraint. Progress notes verified restraint related records. Interview with the GP confirmed being part of the restraint decision making process.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>There is evidence of monitoring and quality review of restraint-use at the facility. The restraint minimisation meeting minutes showed review of their compliance with the requirements of the standard. Restraint analysis is completed monthly by the business and care, clinical and clinical and quality managers.</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)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	The complaint process and forms are made available to residents. Staff interviews confirmed that residents and family are encouraged to raise any concerns and provide feedback on services. Residents and family interviews confirmed that they are aware of the complaints process. The registered nurses and health care assistants (HCA) record any change or resident concerns in resident progress notes. However, during interviews; two residents and two family members had concerns that the verbal concerns/complaints were not actioned. Interviews with staff illustrated that complaints information is not always passed on to management resulting in the complaints process not always being followed, and therefore complaints were not always documented, actioned and resolved. This was confirmed in interview with the CM, as the CM was not aware of verbal complaints or that staff try to resolve verbal complaints without following process.	Verbal complaints are not consistently managed according to Right 10 of the Code.	Ensure verbal complaints are managed according to Right 10 of the Code. 30 days
Criterion 1.3.7.1	PA Low	The service has an activities programme and YPD residents are welcome to attend. The	i) The	i) The

<p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>programme is displayed and implemented, however, attendance records are not maintained.</p> <p>Interviews with older persons and their families confirmed the programme meets their needs. However, the activities programme does not reflect occasions where specific activities for younger persons occur.</p> <p>Clinical notes of young people (including younger persons who are not under a YPD contract) and interviews with younger persons and their families, confirmed there were no specific support plans addressing their individual social needs, for example, community participation; social outings; participation in education; recreation; leisure; cultural and community events consistent with their interests, abilities and preferences. Interviews with family confirmed that the facility relies on family to provide activities.</p>	<p>attendance records for residents participating in activities are not current.</p> <p>ii) The activities programme does not reflect occasions where specific activities for younger residents occur.</p> <p>iii) Residents who are under the age of 65, do not have specific support plans addressing their individual wellness and social needs.</p>	<p>service to ensure that attendance records are current.</p> <p>ii) The activities programme to reflect occasions where specific activities for younger residents occur.</p> <p>iii) Residents who are under the age of 65, to have specific support plans addressing their individual wellness and social needs.</p> <p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.