Oceania Care Company Limited - Atawhai Rest Home and Village

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:	Atawhai Rest Home and Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 February 2019 End date: 5 February 2019

Proposed changes to current services (if any): Reconfiguration of a laundry area into a dual purpose room.

Total beds occupied across all premises included in the audit on the first day of the audit: 81

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

Atawhai Rest Home and Village can provide services for up to 83 residents requiring rest home or hospital level of care. There were 81 residents at the facility on the first day of the audit.

This certification audit was conducted to establish compliance with the relevant Health and Disability Services Standards and the facility's contract with the district health board. This audit also included review of the conversion of a laundry area into a room for use as a dual purpose bed. Review confirmed the room was fit for purpose.

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

The business and care manager is responsible for the overall management of the facility and is supported by a clinical manager, the regional clinical and quality manager and the executive management team. Service delivery is monitored.

There was an area identified as requiring improvement relating to corrective actions from meeting minutes, complaints as well as incident and accident records were not documented to the detail required.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

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 are accessible at the facility. This information is also brought to the attention of residents and their families on admission.

Residents and their families confirmed they are informed and have choices relating to the care they receive. Residents and family members confirmed their rights are being met. Staff are respectful of the needs of residents and communication is appropriate.

Policy and procedures relating to the complaints management process comply with the Right 10 of 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.

Oceania Healthcare Limited is the governing body responsible for the services provided at Atawhai Rest Home and Village. A business plan for 2019, currently in draft and awaiting feedback from the district health board, documents the scope, direction, goals, values and mission statement of the facility.

The facility implements the Oceania Healthcare Limited quality and risk management system. The quality and risk management plan supports the provision of clinical care and quality improvement at the facility. Policies are reviewed. Business status reports to the national support office are completed monthly. Business reports include monitoring of service delivery and quality and risk performance. Benchmarking reports include clinical indicators, infections, incidents/accidents and complaints. An internal audit programme is implemented. There is an electronic database to record risk.

The facility is managed by a business and care manager who is supported by a clinical manager. The clinical manager is a registered nurse and is responsible for oversight of clinical services. The Atawhai management team is supported by the regional clinical quality manager.

Policies and procedures to guide human resource management are implemented. Recruitment and employment practices are aligned with legislative requirements. Registration with professional bodies is verified annually for all staff who require these. A training programme is in place and implemented. In-service education and training is provided for all staff. Mandatory training around clinical service delivery is evident. Staff competency is routinely assessed.

Staffing levels are appropriate across the facility. Registered nurses are on duty twenty-four hours a day, seven days a week. The registered nurses are supported by adequate care and support staff. There is at least one staff member on duty at all times with a current first aid certificate. The service has an on-call programme in place for support from senior staff, when needed. Rosters showed that staff are replaced when on leave or not able to work.

The service uses an electronic resident information management system with password protections to prevent 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.		Standards applicable to this service fully attained.

The residents' records reviewed provided evidence that all residents had been assessed prior to admission to this facility by the needs assessment service coordinators. The residents' needs are assessed on admission by a registered nurse and the initial care plan is developed. The residents' files provided evidence of documented residents' needs, goals and outcomes that are reviewed on a regular basis. Short-term care plans for acute conditions are implemented when required. Nursing care plan evaluations are documented, resident-focused and indicate progress towards meeting residents' desired outcomes. The residents and families interviewed reported being informed and involved.

Planned activities are appropriate to the residents assessed needs and abilities. Residents expressed satisfaction with the activities programme. The activities programme includes a wide range of activities and involvement with wider community. Individual activities are provided either within group settings or on a one-on-one basis. Special consideration is given to younger people with disabilities when planning the activities programme.

Review of the medication systems and medication round evidenced compliance with legislative requirements, regulations and guidelines. There is evidence of three monthly medication reviews being completed by the general practitioner. The contracted pharmacist audits the medication records.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. There is a current food control plan. All meals are cooked onsite in a commercial kitchen. Resident interviews verified 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.

There is a current building warrant of fitness. The service has a planned preventative and reactive maintenance programme in place and complies with legislative requirements. Maintenance programmes include equipment and electrical checks.

Bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has a call-bell system in place used by residents to call for help, when needed. Essential security systems are in place to ensure resident safety. The service completes six monthly trial fire evacuations.

Policies and procedures are documented and implemented for cleaning and waste management. Staff receive training to ensure the safe handling of waste and hazardous substances. There was evidence adequate sluice; cleaning, safe storage of chemical equipment; and correct use of protective equipment and clothing. An on-site centralised laundry run by an external company provides a daily laundry service.

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.

Policies and procedures comply with the standard for restraint minimisation and safe practice. The restraint minimisation and safe practice programme defines the use of restraints and enablers. Restraint minimisation is overseen by the clinical manager. The service has a current, up-to-date restraint register. There were two residents using restraint and twelve residents requesting the use of enablers on the days of audit.

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 control programme, content and detail are appropriate for the size, complexity and degree of risk associated with the service. The service provides an environment which minimises the risk of infections to residents, staff and visitors.

Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. Staff demonstrated adherence to accepted good practice principles around infection control.

Specialist infection prevention and control advice can be accessed from the district health board; microbiologist, general practitioners and infection control specialists if needed.

A registered nurse is the infection control nurse. Surveillance is undertaken, analysed, trended and results are reported to management and 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	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff receive training in the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights' (the Code) at least annually as confirmed in records sighted. Care staff were observed interacting with residents in a respectful and supportive manner. Staff were able to provide examples on ways the Code is implemented in their everyday practice, which includes residents' privacy and providing choices. Residents are encouraged to be independent and able to practise their own values and beliefs. Residents and family members verified that services are provided with dignity and respect. Education relating to the Code, including the complaints process, is provided by Health and Disability Advocacy services and as part of grow, educate and motivate (GEM) study days.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the	FA	Policy and procedure are in place to guide staff in relation to obtain informed consent, including guidelines for obtaining consent for resuscitation and advance directives. The GPs sign to state the competence of the resident and the resuscitation status discussed with the resident and or their family. The information pack for new residents and their families/whānau includes information regarding informed consent. The BCM and CM discuss informed consent processes with residents and their families/whānau

information they need to make informed choices and give informed consent.		during the admission process. Staff ensure that all residents are aware of treatment and interventions planned. Resident and significant others/EPOA are included in the planning of that care. Residents' files identified that informed consent is obtained. Staff confirmed their understanding of informed consent processes.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Policies and procedures are in place to guide advocacy and support for residents who require to access independent advocates when needed. The role of advocacy services is included in training on the Code which is provided to staff during GEM study days. Information on advocacy services through the Health and Disability Commissioner's Office is provided to residents and families. Information on advocacy services is made available at the entrance to the service along with nationwide advocacy details. Families and residents identified that the service provides opportunities for the family or EPOA to be involved in decisions. Residents and family confirmed that advocacy support is available to them if required, including information on how to access a Health and Disability advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy. Residents may have visitors of their choice at any time. Visitors can access the facility after doors are locked at night, using the bell at the entrance to call staff to obtain access. Families confirmed they could visit at any time and are always made to feel welcome. Residents, including YPD, are encouraged to be involved in community activities and to maintain networks with family and friends. Residents' files reviewed and handover demonstrated that progress notes and the content of care plans include regular outings and appointments.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and procedures are in line with the Code and include periods for responding to a complaint. The BCM is responsible for managing complaints. Complaint forms are available at the entrance of the facility and provided in facility information packs. There were 6 complaints for 2018 and 2 for 2019, including 2 complaints that were reported to external agencies. Evidence relating to each lodged complaint is held in the complaints folder and register. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner. The outcomes of the investigation and identified corrective actions are discussed with the

		complainants as verified in interviews. However, there is no written record with evidence of the corrective actions required, actions implemented, identification of the person responsible for the implementation, timeframes for implementation or sign-off after implementation (refer to 1.2.3.8). Staff, residents and family confirmed they knew the complaints process. Residents and family stated that complaints are dealt with as soon as they are identified. Residents and family members were able to describe their rights and advocacy services in relation to the complaints process. The review of the two complaints referred to above and reported to the Health and Disability Commissioner showed that the complaints have been closed. Interview of staff and documents reviewed confirmed improved communication with processes in place to ensure timely referrals to the GP and responses for residents to be reviewed. In addition, on review of the medication management system, improvements have been made to ensure medications are prescribed correctly.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The business and care manager (BCM) and the clinical manager (CM) discuss the Code with residents and their family during the admission process. Discussion relating to the Code is also included on the agenda and discussed at the residents' monthly meetings. Resident and family confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. The posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English. Residents and family receive copies of the Oceania Healthcare Limited (Oceania) handbook which includes information on residents' rights and confirmed they had access to an advocate when needed.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has a philosophy that promotes dignity, respect and quality of life. Conversations of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings. Healthcare assistants (HCA) report that they knock on bedroom doors prior to entering rooms, this was observed on the days of the audit. Residents' files reviewed, including a file of a young person with a disability (YPD), confirmed that cultural and/or spiritual values and individual preferences are identified. Policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate manner. Policy and guidelines provide strategies for the management of inappropriate behaviour. Young people with disabilities, are able to maintain their personal, sexual,

		cultural, religious and spiritual identity. The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe how to recognise this. There were no documented incidents of abuse or neglect in the business status reports or on the incident/accident forms reviewed in residents' files. Residents, staff, families and the general practitioner (GP) confirmed that there was no evidence of abuse or neglect. Staff were aware of the need to ensure residents are not exploited, neglected or abused and staff described the process for escalating any issues.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Policies and processes are in place and implemented to guide culturally safe services and to eliminate cultural barriers. There are processes in place to ensure residents who identify as Māori have their needs met. The rights of the residents/whānau to practise their own beliefs are acknowledged in the Māori health plan, which forms part of the quality plan. The Māori health plan includes the principals of the Treaty of Waitangi. Residents have access to Māori support and advocacy services if required. Cultural training for staff is provided as part of the GEM study days. The diversional therapist (DT) completes cultural assessments on admission and reviews activity plans six monthly.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents and families confirmed they are involved in the assessment and the care planning processes. Residents' files reviewed demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents including family/whānau contact details. Residents interviewed confirmed their spiritual needs are met. Documentation reviewed provided evidence that appropriate culturally safe practices are implemented and maintained. Care staff confirmed an understanding of cultural safety in relation to care.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial,	FA	Policies and procedures are implemented to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Job descriptions include the responsibilities of position including ethical issues relevant to the role. Staff complete orientation and induction; including recognition of discrimination, abuse and neglect. Staff

or other exploitation.		training includes discussion of the staff code of conduct and prevention of inappropriate care.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Policies include current good practice and are aligned with legislative requirements and guidelines. Staff described practices based on policies and procedures. Staff have access to information on good practice as provided by governing bodies and specialists in the region. The service has an annual staff training programme in place. Training is provided by specialist educators as part of the in-service education programme; GEM study days. Registered nurses (RNs) attend compulsory education at the district health board (DHB) and complete the professional development and recognition programme through the DHB.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Accident and incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/EPOA of any accident/incident that occurs. The open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and families. These procedures guide staff on the process to ensure full and frank open disclosure is practised. The GP interviewed confirmed they are confident with the current escalation process in place and that referrals from RNs are timely and appropriate. Review of documentation in response to a complaint to the Health and Disability Commissioner evidenced an amended communication process and a 'major medical event – multidisciplinary communication tool.' Interviews with the GP, CM, charge nurses (CN) and RNs confirmed this tool is an effective guide to communication following a major medical event. Clinical files reviewed evidenced timely and open communication with residents and their family members. Communication with family members is recorded in family/whānau records and progress notes. There is evidence of communication with the GP. Interviews with residents, including YPD, confirmed they are satisfied with the level and detail of communication. A facility newsletter is provided monthly. Families and residents are informed of the range of services provided. Residents sign an admission agreement on entry to the service. Admission agreements provide information around what is paid for by the service and by the resident. Interviews with residents and families confirmed their satisfaction with the services provided at this facility. Interpreter services can be accessed from the DHB when required. There were no residents at the facility needing interpreter services during the on-site audit.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Atawhai Rest Home and Village (Atawhai) has a documented mission statement, values and goals, which are displayed on the wall in the main entrance. On the days of audit the facility was in the process of having the entrance painted and therefore did not have this information displayed. This information is also communicated to residents, staff and family through posters, information in booklets and in staff training. The facility is part of the Oceania group with the executive management team providing support to the facility. Meetings between the facility and executive management occur monthly with the regional clinical and quality manager providing support during the audit. Monthly business status report provides the executive management with progress reports against key quality indicators. The draft business plan is specific to Atawhai with a mission/vision that is linked to the Oceania values. Atawhai is managed by a BCM who is supported by a CM. The BCM is a qualified chef, has previously worked as the regional kitchen manager for Oceania and also managed the Atawhai kitchen. The BCM's previous experience included having managed a business for over 20 years. The BCM has been in the position for 2.5 years. The clinical care at the facility is overseen by the CM who is a RN and has been in this position for approximately 18 months. The CM previously worked in the service as a RN for more than 7 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. Atawhai is certified to provide rest home, and hospital level care up to 83 beds, including the reconfigured laundry to a bedroom. There were 81 beds occupied at the time of the audit. Occupancy included 38 residents requiring rest home level care and 43 requiring hospital level care. The service has contracts with the DHB for the provision of chronic health care; respite; day-care and engaged (acute respite care) services. There were three residents receiving care under the YPD contract. There were no residents receiving care under the chronic health care; acute rehabilitation or day-care contracts. There was one resident receiving respite care. Within the care facility there are 19 care suites that are occupation right agreements (ORA). The ORAs are included in the total occupancy numbers with 13 residents receiving rest home care and five residents receiving hospital level of care.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the	FA	The service has appropriate systems in place to ensure the continuity in day-to-day operations should the BCM or the CM be absent. The CM, with support from the regional clinical and quality manager, stands in when the BCM is absent. The service has a contractor, who previously worked for Oceania in the role of CM, who stands in for the CM when away.

service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		The CM is on call after hours if required. Oceania support office provides additional assistance when needed.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	Atawhai uses the Oceania quality and risk management framework. Policies and procedures guide service delivery. Policies are subject to annual and bi-annual reviews. Policies are linked to the Health and Disability Services Standards, current and applicable legislation and evidenced based best practice guidelines. Policies are available to staff in hardcopy. New and revised policies are presented to staff to read and staff sign to confirm they have read and understood the policy. Staff stated they read new or revised policies. Service delivery is monitored through review of: complaints; incidents and accidents; surveillance of infections; pressure injury and soft tissue/wound reviews; and implementation of an internal audit programme. Review of the quality improvement data provided evidence the data is being collected, collated, evaluated, and analysed to identify trends. The data is reported to staff and to the national support office. Staff interviewed reported they are kept informed of quality improvements. Internal audit schedules and completed audits were reviewed and evidenced corrective action plans were documented when required. Monthly meetings include: staff meetings; quality meetings; health and safety; RN and resident meetings. Bi-monthly meetings include; infection control and restraint meetings. Meeting agendas and meeting minutes are in template format. Meeting minutes identify areas for improvement and implement changes, however, the corrective action process is not consistently documented identifying the required changes; the persons responsible for the implementation of the corrective actions and timeframes for implementation. Complaints management processes are completed and reflected in the complaints register and verbally discussed with complainants, however, the corrective actions are not consistently documented. Although changes are implemented the corrective action process could not be verified for all complaints. Incident and accidents are recorded with detail on what occurred, the interventions at the time of the issue; with corrective actions identified, however, where neurological observations were indicated, the neurological observations were not continued as required in alignment with specified timeframes (refer to 1.2.4.3). Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. The health and safety manual documents health and safety management systems including: a health and safety plan; employee participation; audits; accident reporting; injury management; hazard management; contractor agreements; and an emergency plan.

		Resident/family satisfaction surveys are completed six monthly and results confirmed residents' satisfaction with the levels of care they receive. Residents, including YPD, confirmed their participation in decision making, and having access to technology and the equipment they may need.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low	The BCM is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles. HealthCERT has been informed of the appointment of the new CM. The sentinel report for reporting a pressure injury; stage three, was evidenced. There were also two complaints reported to the Health and Disability Commissioner which were closed. Adverse, unplanned or untoward events are recorded on an accident/incident form. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the BCM. Accident/incident reports reviewed had corresponding corrective action plans in place. However, incident/accident reports reviewed for unwitnessed falls evidenced neurological observations were not always documented as required. There is evidence of open disclosure for recorded events. Staff inform families after adverse events, as confirmed in clinical records and during family and resident interviews. Information is regularly shared at monthly meetings with accidents/incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	The service has policies and procedures in relation to human resource management available and implemented. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and lines of communication. Review of staff files evidenced: employment agreements; reference checks; criminal vetting; drug testing; and completed orientation and competencies. Current copies of annual practising certificates were sighted for staff and contractors that require them to practise. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed. An orientation/induction programme is available and new staff are required to demonstrate competency on a number of tasks, including but not limited to personal care and emergency and security systems. Health care assistants confirmed their role in supporting and buddying new staff. The organisation has an annual training and education programme which includes mandatory education and training documented. Staff complete in-service training around a variety of clinical topics. Individual staff attendance records and attendance records for each education session were reviewed and

		evidenced that ongoing education is provided during GEM study days. Education and training hours are at least eight hours a year for each staff member. The RNs' training records reviewed evidenced eight hours or more of relevant training. Eleven of fourteen RNs have completed interRAI assessment training and competencies. Annual competencies are completed by care staff, for example: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; and restraint. The appointment of service providers safely meets the needs of residents, including those with ORAs.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters showed that staffing levels meet resident acuity and bed occupancy. There are 76 staff, including the management team, clinical staff, leisure/activity staff, and housekeeping staff. There is a RN on each shift. Care staff interviewed reported adequate staff is available and that they can get through their work. Residents and families confirmed staffing is adequate to meet the residents' needs. The residents who are receiving care in the ORA suites 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.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	There are policies and procedures in place for privacy and confidentiality of residents' records. The service retains relevant and appropriate information to identify residents and track residents' records, including information collected on admission with the involvement of the family. Staff interviews confirmed they are familiar with the electronic record management system. The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals which are either directly entered by the user or are scanned in to the system. Resident records are in hard copy and medicines records are mainly in electronic format. In interviews, staff described the procedures for maintaining confidentiality of residents' records. All records are accessible by authorised personnel only. Resident care and support information can be accessed in a timely manner. Documents containing sensitive resident information are not displayed in a way that could be viewed by other residents or

		members of the public. Archived records are securely stored and easily retrievable. Residents' progress notes are completed on every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes identify the name and designation of the person making the entry.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Needs Assessment and Service Coordination Service (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. The information pack provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service processes ensure compliance with entry criteria. 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.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a policy that describes guidelines for discharge, transfer documentation and follow-up. A record is maintained and a copy is kept on the resident's file. This was verified in resident files reviewed where applicable. All relevant information is documented and communicated to the receiving health provider. A transfer form accompanies residents to receiving facilities. Staff interviewed stated that follow-up occurs to check that the resident is settled.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and processes that describe medication management that align with current legislation and accepted guidelines. Medications are checked against the resident's medication profile on arrival from the pharmacy by a RN. 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 registers are maintained and evidenced weekly checks and six-monthly physical stocktakes. There is a six-monthly review of medicine usage, by a pharmacist and recommendations for appropriate stock levels and management are made in consultation with the CN and/or CM where necessary. A system is in place to ensure medicines are prescribed correctly. Medicine reconciliation is completed on admission by the RN and GP. A computerised medication management system is used at the facility and meets the current legislative requirements and safe practice guidelines.

		The medication round was observed at lunch time and evidenced practice was safe and met the requirements of the standard. All staff authorised to administer medicines have current competencies. Administration records are maintained, as are specimen signatures. Staff education in medicine management is provided. The fridges in each area where medications are kept, evidenced a weekly temperature check and temperatures within the recommended range. Residents' who request to self-administer medicines are provided with secure storage for their medicines. Younger persons are supported to self-administer medicines where appropriate. An initial assessment to verify the resident's safety and competency to administer medicines is completed by the GP. There were no residents self-administering their medication on the days of audit. There were no standing orders in use at time of audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The kitchen manager/chef oversees food provision at Atawhai. All food is prepared onsite in a large commercial kitchen. There is a current food control plan. The kitchen and the equipment are well maintained. Food safety information and a kitchen manual are available in the kitchen. All kitchen staff had completed relevant food safety training. Food in the chiller was covered and dated. The kitchen was clean and all food was stored off the floor. Food audits are carried out as per the yearly audit schedule. There is a four weekly seasonal menu approved by a dietitian at organisational level. Diets are modified as required. At interview, the kitchen manager/chef reported the RN completes each resident's nutritional profile on admission with the resident and family. The service encourages residents to express their likes and dislikes. The kitchen manager/chef interviewed stated they visit each new resident to confirm preferences and are kept informed of any changes. Special diets are catered for and documented in the kitchen. Meals are plated in the kitchen and delivered to the main dining room. A tray service is also provided. Food temperatures are monitored. Special equipment, to meet residents' nutritional needs, is readily available. Residents requiring extra support to eat and drink are assisted, this was observed during lunch. The residents interviewed spoke highly about meals provided and they all stated that staff ask them about their food preferences.
Standard 1.3.2: Declining Referral/Entry To Services	FA	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 and the GP are informed of the decline to entry. The residents would be declined entry if not within the scope of the service or if a

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.		bed was not available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial nursing assessment and the initial care plan are completed within 24 hours of resident's admission. The residents have their needs identified through a variety of information sources that include but are not limited to: the NASC interRAI home care assessments; GPs; specialists; other service providers involved with the resident; the resident and family. The residents' files evidenced residents' completed discharge/transfer information from the DHB, where required. 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: dietary; continence and pain. Residents interviewed confirm assessments are conducted according to their needs and in a private manner. Review of environment and interviews with staff confirmed resources and equipment available meet the needs of residents. Interviews with residents and family confirmed their involvement in the assessments, care planning, review, treatment and evaluation of residents' care.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The RNs develop PCCPs with the resident and family/whānau involvement included where appropriate. All files sampled had an individualised PCCP that covered all areas of identified needs. Short-term care plans are developed for the management of acute problems, when required, and signed off by the RN when problems are resolved. Review of wound care documentation evidenced all wounds (including skin tears) are recorded on short-term care plans. Interview with residents and staff; review of nursing progress notes, specialist and GP progress notes; and monitoring records confirmed continuity of service delivery. Interviews with residents confirmed they have input into their care planning and review and that the care provided meets all their needs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate	FA	The documentation, observations and interviews verified the provision of care to residents was consistent with the residents' needs and their desired outcomes. The residents' care plans evidenced detailed interventions based on assessed needs, and desired outcomes or goals of the residents. Family/whānau communication is recorded. Resident observations are not always documented within the required

and appropriate services in order to meet their assessed needs and desired outcomes.		timeframes (refer to 1.2.4.3). There is evidence in the resident records of appropriate links developed and maintained with other services. Review of resident's records confirmed timely referrals to GPs and other health professionals. In interviews, staff confirmed they are familiar with the current interventions of the residents they were allocated. The facility has appropriate resources and equipment, as confirmed at staff interviews and through visual observation. The equipment available complies with best practice guidelines and meets the residents' needs. In interviews, residents and family confirmed current care and treatments meet their needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Interviews with the DT and review of residents' files confirmed an individual activities plan is developed for each resident. All recreation/activities assessments and reviews are completed in a timely manner. Residents have an activities assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career and family. Younger person specific activities include, but are not limited to: involvement with the local community; accompanying and assisting staff with projects. Activities are planned, age appropriate, meaningful to residents and reflect ordinary patterns of life. There are visits from community groups. Some residents attend activities of interest in the community and the facility provides weekly van outings. Residents who prefer to stay in their room can have one-on-one visits including, for example, reading, hand massage and music. There is a theme allocated monthly and activities are planned around the theme. The residents' activity needs are evaluated regularly and as part of the formal six-monthly multidisciplinary care plan review. The DT interviewed stated that they participate in the six monthly multidisciplinary meetings. The residents' attendances and participation in activities are monitored and activities monthly progress reports are entered in the residents' clinical files. The activities are discussed at the residents' meetings and indicate residents' input is sought and responded to. Residents interviewed confirmed they are satisfied with the programme offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely	FA	There are three-monthly medical reviews by the GP. There was documented evidence that RN evaluations were current and completed for all care plans sampled. Resident care is evaluated on each shift and reported in the residents' progress notes. If any change is noted it is reported to the RN, CN and/or CM. A short-term care plan is initiated for short-term concerns, such as infections and wound care. There is

manner.		evidence short-term care plans are signed off when completed or added to the PCCP if the problem is ongoing. Interviews verified residents and family/whānau are included and informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	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, CN or CM sends a referral to seek specialist service provider assistance from the DHB. Referral forms and documentation are maintained on residents' files. Referrals are followed up on a regular basis by CN, CM or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Policies and procedures provide guidelines for staff in the management of waste and hazardous substances. These policies and procedures specify labelling requirements in line with legislation, including the requirements for labels to be clear, accessible to read and free from damage. The hazard register is current. Material safety data sheets are available and accessible for staff. Staff receive training and education in safe and appropriate handling of waste and hazardous substances. Interviews with staff and observation confirmed there is personal protective equipment available and used in high risk areas.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service has a current building warrant of fitness displayed. The entrance to the facility was being re-painted at the time of audit. There has been a reconfiguration of the conversion of converting a laundry area into a dual purpose room since the last audit. Interview with the resident occupying this dual purpose room and observation confirmed this room is fit for purpose. The service provides mobility access throughout the facility, meeting requirements of residents including YPD. There are quiet areas throughout the facility for residents and their visitors to meet and there are areas that provide privacy when required. There is access to internal courtyards and external garden areas with outdoor furniture and shade. Interview with the area maintenance supervisor and full time facility maintenance supervisor confirmed there is a planned and reactive maintenance schedule in place. The medical equipment had been checked and calibrated for safe use. The service has an annual test and tag programme and this is up to

		date, with checking and calibrating of clinical equipment annually. The maintenance person confirmed the hoists are checked monthly. Interviews with staff and observation of the facility confirmed there is adequate equipment. The YPD resident interviewed confirmed having equipment that met their needs. Hot water temperature testing evidenced temperatures were within safe levels. Interviews with the maintenance supervisor confirmed that if the hot water temperatures exceed the recommended temperatures, corrective action is taken to address this.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	Toilets are located close to the communal areas. Separate toilets are provided for visitors and the staff members have their own bathroom/toilet facility. All the toilets have a system that indicates if it is engaged or vacant. The bathroom facilities are of an appropriate design to meet the needs of the residents. Residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Residents and family members reported that there are sufficient toilets and showers. Auditors observed residents being supported to access communal toilets and showers in ways that were respectful and dignified.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All rooms and suites facilitate single accommodation only. There are 73 dual purpose care suites and 10 rest home level care suites. There are 37 full ensuite bathrooms. There is adequate space for resident, staff and mobility equipment in the room at any time. Residents' rooms are individualised with their own furnishings, photos and other personal possessions. Residents and families are encouraged to make the room their own.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation,	FA	Lounge areas and dining areas are large enough to accommodate all residents. The service has three lounge areas that can be used for activities, and one large dining room facilitating dining space for all residents. All areas are easily accessed by residents and staff. Residents, including YPD, can access areas for privacy, when required. A café overseen by the food services manager is located adjacent to the dining room, with tables and chairs for residents to have coffee. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.

activity, and dining needs.		
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The laundry service is completed off-site at a central laundry service provided by Oceania for its facilities in the region. There are processes in place for daily collection, transportation and delivery of linen. Residents' laundry is sorted and delivered to their rooms by a staff member employed to include this duty, which facilitate staff familiarity of residents clothing and minimising of lost property. The effectiveness of the cleaning services is audited as part of the internal audit programme. There are cleaners on site during the day, seven days a week. There are safe and secure storage areas for chemicals and cleaning products. The chemicals are administered through a closed system which is managed by a contracted chemical company. The cleaners have a trolley to put chemicals in and the cleaners are aware that the trolley must be with them at all times. The cleaner has specific guidelines, in the form of a flip-chart, to ensure appropriate cleaning processes. Products are used with training around use of products provided throughout the year. The cleaner interviewed confirmed that they had training at least annually. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility. Residents and families stated they were satisfied with the cleaning and laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The service has documented systems in place for essential, emergency and security services. Registered nurses, HCA, the leisure/activities coordinator and the people who drive the van with residents in it, are required to complete first aid training. There is at least one designated staff member with first aid training on each shift. Emergency and security management education is provided at orientation and at the in-service programme. Staff records provided evidence of current training relating to fire, emergency and security. There is a system in place for security to ensure all entrances are locked after dark. Staff complete security checks at set intervals. Staff can identify visitors after hours when the security system is activated through the computer screen in the nurses' stations. Families and residents, including YPD, know the process of alerting staff when in need of access to the facility after hours. There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service. Visitors and contractors are required to sign in and out of visitors' registers, as observed on audit. The service had a fire evacuation scheme which has been approved. The services' emergency plan considers the needs of YPD in an emergency. Information in relation to emergency and security situations

		is readily available/displayed for staff and residents. Emergency equipment is accessible, current and stored appropriately with evidence of emergency lighting, torches, gas and barbeque for cooking, extra food supplies, emergency water and blankets. There is motion activated lighting around the facility. Interview with the maintenance person confirmed there is a generator if required. The service has a call bell system in place, which is being upgraded to an escalation system; where call bells not being answered are escalated to the CM; the BCM; regional and national management. All residents have access to a call bell. Call bells are checked monthly by the maintenance person. Residents confirmed staff respond to call bells in a timely manner.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light, safe ventilation and heating. Policies and procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation. Interviews with the area maintenance supervisor and facility maintenance supervisor confirmed environmental temperatures are monitored quarterly. Families and residents confirmed that rooms are maintained at an appropriate temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The RN is the infection control nurse (ICN) with support from the CM, BCM, the regional clinical quality manager, and the Oceania infection control committee and infection control team. A documented job description for the ICN, including role and responsibilities is in place. Oceania has an established infection control programme. The infection control programme is reviewed annually. The infection control programme, including its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Internal audits conducted include hand hygiene and infection control practices. The facility provides an environment that minimises the risk of infection to residents, staff and visitors through the implementation of the infection prevention and control programme. Hand sanitizers and gels are available for staff, residents and visitors to use. Infection control meeting minutes are available for staff. Staff interviewed demonstrated knowledge of the infection prevention and control programme and practices.
Standard 3.2: Implementing the	FA	The ICN is responsible for implementing the infection prevention and control programme. Infection control is a standard agenda item at the facility's meetings. The ICN has access to external infection control

infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		specialist advice, if required. The ICN is aware of the need to analyse data and the reasons behind this. Staff are made aware of residents' infections through staff handovers, short-term care plans and residents' progress notes. The ICN has access to all relevant infection control resident data to undertake surveillance, internal audits and investigations. Observations during the on-site audit confirmed implementation of infection prevention and control procedures such as hand washing and the use of anti-bacterial hand gels.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	Oceania has documented infection prevention and control policies and procedures in place that reflect current best practice. The infection control manual includes a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, and training and education of staff. The infection control policies link to other documentation and uses references where appropriate. Infection control policies are current and have been reviewed as part of the policy review process by Oceania support office. Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and the location of infection control policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control nurse is responsible for the training of staff in the facility. Infection control education for staff starts at orientation and induction of new staff and ongoing training is provided through the organisation's annual education and training programme or at an ad-hoc basis when required. The ICN completes training in infection prevention and control through updates at the DHB and e-learning. Interview confirmed information is provided to residents and visitors that meets their needs.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been	FA	Definitions of surveillance and types of infections are clearly defined and documented to guide staff. The surveillance is appropriate for the size and complexity of services provided. Infection data is collected and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. The service submits data monthly to Oceania support office where benchmarking is completed. This data is reported to the quality, RN and staff meetings.

specified in the infection control programme.		Infection control alerts were documented on the individual residents' records reviewed. All staff are required to take responsibility for surveillance activities. Interviews with staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers and progress notes. This was evidenced attending handover and review of the residents' files. Interview with the ICN and review of documentation evidenced there was one outbreak since the previous audit. This was reported to the authorities in a timely manner. The GP, CM and ICN interviewed stated they accessed specialists at the DHB at the time of the outbreak. The outbreak management resulted in with minimal spread.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The Oceania restraint minimisation and safe practice handbook and policies comply with the standard and relevant legislation. There were two restraints (bedrails/chair brief) and twelve enablers in use at time of audit. The required documentation relating to restraint use was recorded. Staff and management interviews confirmed the approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The service has policies and procedures in place to guide staff in the management of restraints. Education records sighted evidenced staff received education on restraint minimisation and safe practice. The CM is the restraint coordinator and is responsible for restraint processes at the facility. Interviews confirmed that the restraint approval process forms part of the medical review. For the restraint in use at the time of audit, the restraint approval process had been followed and a current consent was in place for the use of restraint.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The two residents' records reviewed for restraint use included consent and assessment which meet the criteria as outlined in this standard. Culturally safe practice was maintained throughout restraint use, as evidenced in care planning.

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Interviews with staff and review of the PCCP confirmed alternatives to restraint use is considered prior to commencing restraint. The restraint register reviewed was up to date. The register records the residents' name, the type of restraint being used, when it was initiated and opportunity to record the date of when it is discontinued. Consent for restraint in use at the time of audit was in place and restraint risks recorded. Restraint monitoring is maintained. Staff are aware that advocacy services and support are available, the contact detail is documented, and the services can be accessed when needed.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Interviews with staff confirmed evaluations of any restraint are to be completed at three-monthly intervals. The restraint records reviewed for restraints in use at the time of audit had three-monthly restraint evaluation completed. Consent forms for restraint included timeframes for daily monitoring. The restraint coordinator/CM and RNs maintain communication with families regarding restraint use.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint coordinator reports on restraint management at monthly meetings. The three-monthly restraint review includes effectiveness of the restraint, compliance with policy and procedures, adverse events related to restraint use, and the possibilities of discontinuing restraint. Interviews with staff confirmed that monitoring of restraints is taking place according to the frequency as recorded in the consent record.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Internal audit schedules and completed audits were reviewed and evidence corrective action plans were documented when required. Meeting minutes are recorded on templates to ensure consistency of topics covered. Although meeting minutes identify and record opportunities for improvements and other data show evidence that changes are implemented, there is no consistently documented records of the management of required changes; the persons responsible for the implementation of the corrective actions and timeframes for implementation. Complaints management processes are completed and reflected in the complaints register and verbally discussed with complainants. Interviews with staff, residents and family, as well as meeting minutes and review of the complaints register confirmed implementation of changes. Complainants are verbally informed of the implementation of changes and the outcomes of their complaint, however, this information is not consistently documented. Corrective and the management	i) Meeting minutes identifying requirements for improvement do not consistently include recorded evidence of the corrective action required; the person responsible for implementing the corrective action and the required timeframes for implementation. ii) Complaints management processes do not consistently include recorded evidence of	i) Ensure meeting minutes identifying requirements for improvements show documented evidence that corrective actions are implemented; including the corrective action required; the person responsible for implementing the corrective action and the required timeframes for implementation. ii) Ensure all complaints document evidence that corrective actions are implemented including the corrective action required; the person responsible for implementing the

		processes of required changes; the persons responsible for the implementation of the corrective actions and timeframes for implementation are not consistently documented.	the corrective action required; the person responsible for implementing the corrective action and the required timeframes for implementation.	corrective action and the required timeframes for implementation. 90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	Incident/accident records are completed for incidents/accidents which occur. Review of incident/accident records confirmed there is timely review by the RN and corrective actions are implemented. However, three of ten incident/accident records reviewed for unwitnessed falls evidenced neurological observations are not documented as per the required timeframes and best practice.	Incident/accident records for residents who had unwitnessed falls, did not consistently evidence neurological observations occurred over 24 hours, as per policy.	Ensure incident/accident records for residents who experience unwitnessed falls consistently record neurological observations as per policy. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.