

Oceania Care Company Limited - St Johns Wood

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by 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: St Johns Wood

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

Dates of audit: Start date: 24 September 2019 End date: 25 September 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: 53

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

General overview of the audit

St Johns Wood, a facility within Oceania Healthcare Limited can provide care for up to 70 residents requiring rest home or hospital level of care. There were 53 residents at that facility on the first day of the audit.

This surveillance audit was conducted against the relevant Health and Disability Service Standards and the service contract with the district health board.

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

There were no areas requiring improvement at the last certification audit.

There were areas identified as requiring improvement at this surveillance audit relating to: corrective action management; service provider availability; availability of activities; medicines management; and food safety.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is provided to residents on admission and available within the facility.

Staff communicate with residents and family members following any incident as recorded in the residents' files.

Residents, family and general practitioner interviews confirmed that the environment is conducive to communication, including identification of any issues, and that staff are respectful of residents' needs.

There is a documented complaints management system and a complaints register is maintained. The business and care manager is responsible for managing complaints. Complaints are investigated and documented, with corrective actions implemented where required. There has been one complaint forwarded to the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Oceania Healthcare Limited is the governing body responsible for the services provided at St Johns Wood.

The facility has implemented the Oceania Healthcare Limited quality and risk management system that supports the provision of clinical care and quality improvement at the facility. Policies are reviewed. Reports to the national support office allow for the monthly monitoring of service delivery.

Quality and risk performance is monitored through the organisation's reporting systems. Benchmarking reports include but are not limited to: falls; infections; health and safety and complaints. An internal audit programme is implemented. Corrective action plans are documented from quality activity results, with evidence of the resolution of issues when these are identified. There is an electronic database to record risk in which risks and controls are clearly documented.

The facility is managed by an appropriately qualified and experienced business and care manager, supported by a clinical manager who is responsible for the oversight of clinical service provision. Both the business and care manager and the clinical manager are registered nurses. The facility management team is supported by the regional clinical quality manager and the regional operations manager.

Oceania Healthcare Limited human resource policies and procedures are implemented. Newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff and contractors who require them are validated annually. An annual training plan is implemented to ensure ongoing training and education for all staff members.

A review of rosters and service delivery staff, and resident/family interviews confirmed that there is sufficient staff available.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The residents' assessments, care planning and evaluations of care are developed with resident and/or family input, within the required timeframes and coordinated to promote continuity of service delivery. The residents and family confirm their input into assessments, care planning and evaluations of care and satisfaction with services provided at the facility.

A sampling of residents' clinical files evidenced initial assessments, initial care plans and long-term care plans are completed within the required timeframes and include the residents' individualised needs and required interventions. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan.

The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Staff responsible for medicine management attend medication management in-service education and have current medication competencies. The resident self-administering medicines does so according to policy.

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is displayed. There had been no alterations to the building since the last audit.

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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Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The staff interviews confirmed that enabler use is voluntary. There were no residents using enablers and one restraint was being used for one resident during the on-site audit.

The assessment, consent, care planning and review of enabler use, when applicable is conducted and recorded.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided. There have been no outbreaks since the previous audit.

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	11	0	4	1	0	0
Criteria	0	34	0	4	1	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<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 category and a summary of the complaint; how the complainant was contacted (verbal or letter); date of meeting; and the date the complaint was closed/resolved. Evidence relating to each lodged complaint is held in the complaints folder with the register. The complaints reviewed indicated that complaints are investigated promptly and issues are resolved in a timely manner.</p> <p>Resident interviews confirmed that they were aware of opportunities and processes to raise any concerns and provide feedback on services. Staff and resident interviews and residents' meeting minutes confirmed that residents can raise and discuss concerns and provide feedback on services at resident meetings. Residents and family interviews confirmed that they were aware they could make a complaint. They stated that they were satisfied with how any issues raised had been dealt with.</p> <p>Residents and family interviews confirmed an understanding of their rights to advocacy and how to access advocacy services particularly in relation to the complaints process.</p> <p>There had been one complaint copied to the Health and Disability Commissioner (HDC), the HDC had referred this directly to the facility. Following a response from the facility, the HDC had closed the complaint requiring no further action. The complaint was notified to the Ministry of Health on the second day of the audit.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy that sets out the process to guide staff and ensures there is open disclosure of any adverse event where a resident has suffered unintended harm while receiving care. Completed incident forms and residents' records reviewed demonstrated that family are informed if the resident has an incident/accident; a change in health or a change in needs. 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.</p> <p>Monthly resident meetings are chaired independently by an Age Concern representative. The meetings inform residents of facility events and activities and provide attendees with an opportunity to: make suggestions; provide feedback; and to raise and discuss issues or concerns. Upcoming resident meetings are included in the activities planner and advertised in the facility newsletter and held on the same day of each month. Family are welcome to attend the meetings. Minutes from the residents' meetings showed evidence that a range of subjects and issues are discussed, including: the meal service; facility; and health and safety (refer to 1.2.3.8).</p> <p>Resident and family stated that they felt comfortable approaching the business and care manager (BCM) and staff and that issues/concerns raised are responded to promptly.</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 in the event that interpreter services are required these would be accessed through a local marae or the district health board (DHB). At the time of the audit there were no residents for whom English was not their first language.</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>Oceania Healthcare Limited (Oceania) has a documented mission, vision and values statements which reflect a person-centred approach to all residents. These are described in the information pack provided to residents and their families on admission. Staff also receive this information at orientation and in annual training. Oceania has an overarching business plan applicable to this facility.</p> <p>St Johns Wood is part of the Oceania group with the executive management team providing support to their facility. Communication between the facility and executive management occurs at least monthly. The facility provides ongoing electronic reporting of events and occupancy that provide the executive management team with progress against identified indicators.</p> <p>The BCM has been in this role for just under two years. The BCM has 21 years' experience in age related residential care (ARRC), including previous facility and village management experience. The BCM is a registered nurse (RN) with a current practising certificate and has completed Oceania management training. The BCM is supported by a clinical manager (CM). The CM has been in this current role for four months and has over twelve years' experience in ARRC, including previous experience as a CM at this and another Oceania aged care facility. The CM holds a current annual practising certificate and is supported by the Oceania clinical quality manager</p>

		<p>(CQM). The management team have completed appropriate induction and orientation to their roles.</p> <p>The facility is certified to provide rest home and hospital care services for up to 70 residents, with 53 beds occupied at the time of the audit. Occupancy included: 35 residents requiring rest home level care and 18 requiring hospital level care. Total occupancy numbers included: three residents assessed as requiring hospital level care, one who was under the long-term chronic health conditions contract and under 65 years of age; one under the short-term respite contract receiving palliative care; and one resident funded under a contact with Accident Compensation Corporation (ACC).</p> <p>The facility holds contracts with the DHB for ARRC, long-term chronic health conditions, short-term residential respite services, and young persons with disabilities (YPD) as well as a contract with ACC. The facility has 20 residents with occupational right agreements. At the time of the audit there were no residents who had been admitted under the YPD contract.</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>	<p>PA Low</p>	<p>The Oceania documented quality and risk management framework is accessed by staff to guide service delivery. 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 policy updates are also provided as part of relevant in-service education. New and revised policies are also made available on a notice board located in the staff room and staff sign to confirm that they have read and understood each new policy and/or update. Staff interviews confirmed that they are made aware of new and updated policies and also receive alerts through the electronic duty log on system.</p> <p>Service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators such as: falls; infections; medication errors; restraint; sentinel events; weight loss; wounds; and food safety; and implementation of the internal audit programme. Clinical indicators are collated monthly. There is evidence that the annual internal audit programme is implemented as scheduled. Reports show evidence that quality improvement data is being collected and collated with the identification of trends and analysis of data. Where required, corrective action plans from quality activities are developed, implemented, evaluated and closed out. There is communication with all staff of any subsequent changes to procedures and practice through meetings and the electronic duty log on system.</p> <p>All aspects of quality improvement, risk management and clinical indicators are discussed at monthly meetings. However, action points arising from minutes required evidence to support implementation. Staff interviews, and meeting attendance records confirmed that attendance at staff meetings was facilitated. Copies of meeting minutes are available for review in the staff room and staff sign to confirm that they have read and understood these. Staff interviews confirmed that they are kept informed of quality improvements. Residents and family are notified of facility changes and events through the facility's monthly residents' meetings. Residents' meeting minutes, staff and resident interviews confirmed that residents, including those under 65 years of age, can have</p>

		<p>input into quality improvements and facility changes. Interviews confirmed that residents are satisfied that the service meets their individual needs and that they have input into services.</p> <p>Satisfaction surveys for residents and family are completed as part of the annual internal audit programme. Surveys reviewed evidenced satisfaction with the services provided. This was confirmed by resident and family interviews.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and their responsibilities to report hazards, accidents and incidents promptly. Accidents, incidents and corrective actions are discussed at staff meetings. The CM is the health and safety representative. Interview confirmed understanding of the obligations of the role. There is evidence of hazard identification forms completed when a hazard is identified and that hazards are addressed, and risks minimised. A current hazard register is available that is updated at least annually or when a new hazard is identified.</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>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 via Oceania support office staff. The appointment of the CM since the last audit had been reported to the Ministry of Health.</p> <p>Staff interviews confirmed an understanding of the processes. A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the BCM or CM.</p> <p>Staff training records reviewed confirmed that staff receive education at orientation and as part of the ongoing training programme on accident/incident reporting processes.</p> <p>Staff interviews confirmed awareness of the need to identify and report errors or mistakes. Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events.</p> <p>Accident/incident reporting forms are readily available in the staff room. Accident/incident reports selected for review evidenced that where appropriate the resident's family had been notified, an assessment had been conducted and observations completed. Corrective actions arising from accidents/incidents were implemented. There is evidence of a corresponding note in the resident progress notes and notification of the resident's family member where appropriate. Family and resident interviews confirmed that family are notified where the resident has had an accident/incident or a change in health status.</p> <p>Accident/incidents are graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly</p>

		shared at monthly staff meetings.
<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>resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; identification verification; a position specific job description; and a signed employment agreement.</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 and contractors that required them.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. Health care assistants (HCA) are buddied with an experienced staff member until they demonstrate competency on specific tasks, for example: hand hygiene; medication and moving and handling.</p> <p>The organisation has a documented role specific mandatory annual education and training module/schedule, that includes topics relevant to all services and levels of care provided. There are systems and processes in place to ensure that all staff complete their required mandatory training modules and competencies.</p> <p>The CM and five other RNs have completed interRAI assessments training and competencies. Care staff complete annual competencies, for example: moving and handling; hoist use; hand washing; and medication management. Education session attendance records evidenced that ongoing education is provided relevant to the services delivered. Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of relevant education and training hours per annum. An annual appraisal schedule is in place. All staff files reviewed evidenced that staff employed for greater than one year had completed a current performance appraisal.</p> <p>There are sufficient care staff appointed to safely meet the needs of all residents including those residents with occupancy rights agreements.</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>	PA Low	<p>The facility staff consist of: a management team; RNs; enrolled nurse (EN); HCAs; activities assistant; maintenance personnel and household staff. Household staff include: kitchen; laundry and cleaning staff who provide services seven days a week.</p> <p>The organisation's staffing and skill mix policy and formula provide guidance to ensure safe staffing levels within the facility are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract. 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 due to changes</p>

<p>service providers.</p>		<p>in the services provided and the number of residents.</p> <p>There are sufficient RNs and HCAs available to safely maintain the rosters for the provision of care. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy. In addition to the BCM and CM who are on duty Monday to Friday there are two senior RNs, plus one or two other RNs, on morning duty seven days per week, and one RN on each afternoon and night shift. On each: morning shift there are four HCAs working full shifts and four working short shifts; on each afternoon shift three HCAs working full shifts and five working short shifts, plus three HCAs on each night shift.</p> <p>The service has 24 suites that have occupational right agreements (ORA) of which 20 were occupied. There is one resident with an ORA who is living independently. There are also independent living apartments on the upper floor. These are managed by a village coordinator and an EN who assists residents in their cares of daily living where required. Interview with the BCM confirmed, except for occasional telephone advice, rest home and hospital staff do not provide services to the residents in upstairs independent living suites.</p> <p>Until two weeks prior to the audit there were two nurses' stations, one of which was close to the care suites for staff providing care at this end of the facility. These have been replaced by a newly assigned nurses' station in a centrally situated position, but some distance from the care suites. There is one resident at the far end of the care suites who is assessed as requiring hospital level of care.</p> <p>The CM and senior RNs share the on call after hours seven days a week.</p> <p>Observation of service delivery confirmed that resident needs were being met in a timely manner. Residents and family interviews stated that staffing is adequate to meet the residents' needs. Staff confirmed that whilst they are busy at times they have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication area, including controlled drug storage evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The medication register is maintained and evidenced weekly checks and six-monthly physical stock takes. The medication fridge temperatures are completed daily and recorded.</p> <p>All staff authorised to administer medicines have current competencies. The medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and followed procedures and protocols.</p> <p>Electronic medicine charts evidence residents' photo identification, legibility, allergies are recorded and three-monthly medicine reviews are conducted. The residents' medicine charts record all medications a resident is taking (including name, dose, frequency and route to be given).</p> <p>There was one resident self-administering medicine at the facility and this was conducted according to policy. The policy includes facilitation for YPD residents to self-medicate, and at the time of audit no YPD residents met the</p>

		<p>criteria.</p> <p>Not all pro re nata (PRN) prescribing practice met the requirements of the standard. Not all special authority medication approvals were current for residents who required these.</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>	PA Low	<p>In interview, the kitchen staff confirmed they were aware of the residents' individual dietary needs. The residents' dietary requirements are identified on admission, documented and communicated to kitchen staff. The residents' dietary needs reviews are conducted six monthly or when residents' condition alters. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at staff interviews.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weights. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided.</p> <p>The food temperatures are recorded, as are the fridge, chiller and freezer temperatures. All decanted food is dated. Kitchen staff have completed food safety training.</p> <p>The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu.</p> <p>The service does not currently have an approved food plan as not all surfaces in the kitchen promote food safety requirements.</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>The residents' care plans evidenced interventions based on assessed needs and desired outcomes/goals of the residents. The GP documentation and records are current. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the residents they were allocated.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery</p>	PA Low	<p>There is one activities programme for the rest home and hospital residents and includes activities for the resident under 65 years of age. There are various areas where recreational activities are provided. Regular exercises and outings are provided for those residents able to participate. The activities programme includes input from external agencies, planned activities such as festive occasions and celebrations, and supports ordinary</p>

<p>plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>unplanned/spontaneous activities. There are current individualised activities assessments and care plans recorded in the residents' files reviewed. The residents' activities attendance records are maintained. Feedback is obtained from residents and family members by way of satisfaction surveys.</p> <p>In interview, the activities coordinator confirmed their role in the facility's activities programme. The activities coordinator implements the activities programme five days a week. The service does not currently provide activities for all residents over weekends.</p> <p>During the on-site audit there was one YPD resident in the facility; the activities co-ordinator presented an individualised care plan that was consistent with the residents' needs and preferences.</p> <p>There are residents' meetings held at monthly intervals.</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>Timeframes for care planning evaluations are documented and implemented. The residents' care plans are up-to-date and reviewed six-monthly. There is evidence of resident, family, HCAs, allied health staff and GP/NP input into the care plan evaluations. In interviews, residents and families confirmed their participation in care plan evaluations. Wound care plans reviewed evidenced wound management plans were current and evaluated within the required timeframes.</p> <p>The residents' progress records are entered on each shift. When residents' progress is different than expected the RN contacts the GP, as required. Short-term care plans were in residents' files reviewed where required. The family are notified of any changes in residents' condition this was confirmed at family interviews.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</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. The 'men's shed' has been repurposed as a nurses' station and office. However there have been no structural alterations to the building since the last audit.</p>
<p>Standard 3.5: Surveillance</p>	<p>FA</p>	<p>The infection control nurse is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at monthly clinical meetings.</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>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files evidenced the residents' who are diagnosed with an infection have short-term care plans.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the infection control nurse, RN's, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interview, the infection control nurse confirmed no outbreak has occurred at the facility since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enablers in the facility policy documentation are congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There were no residents at the facility using enablers and one residents using restraint at the time of audit.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, was confirmed at staff and management interviews.</p> <p>In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training is provided.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Monthly quality, health and safety, infection control, RN and staff meetings evidenced all aspects of quality improvement, risk management and clinical indicators are discussed. However, action points arising from minutes require evidence to support implementation.</p>	<p>Corrective actions identified at meetings did not consistently evidence that:</p> <ul style="list-style-type: none"> i) These had been clearly identified. ii) A time frame and accountabilities had been identified. ii) Action points had been carried forward to subsequent meetings. 	<p>The facility is to ensure that action points arising from meeting minutes:</p> <ul style="list-style-type: none"> i) Are clearly identified. ii) Include a timeframe and person responsible for actioning these. iii) Demonstrate that these have

			iii) Action points had been closed out	<p>been carried forward and discussed at subsequent meetings.</p> <p>iii) Demonstrate that these have been closed out.</p> <p>90 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>There is one newly commissioned nurses' station with sufficient room to accommodate all staff and residents' files. This room had replaced two nurses' stations that were situated at opposite ends of the facility. The second nurses' station close to the care suites was reinstated on the first day of the audit.</p>	<p>The new sole nurses' station was not sufficiently close enough for observation of all residents specifically those assessed as requiring hospital level care, in the care suite wing.</p>	<p>Ensure that the nurses' stations for the care suites is consistently maintained.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and</p>	PA Moderate	<p>On the medimap electronic charting system the three monthly mandatory review dates were current, and the resident photographs were current, however there were 8 of 12 PRN medication charts that did not indicate maximum medication doses. There were nine special authority medication approval documents where authority dates had lapsed for residents requiring these medications.</p>	<p>PRN medications did not routinely show maximum dose rate and nine special authority medication approval documents were out of date.</p>	<p>Ensure all PRN medications have maximum dose rates over a twenty-four-hour period and special authority medication documentation is current.</p>

guidelines.				60 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	Food procurement, storage, transportation, delivery and disposal comply with current legislation and guidelines, however requirements around production and preparation are not all aligned with current requirements for safe and appropriate food service delivery. Part of the corrective actions raised at the food service audit was implemented however, one kitchen food preparation surface does not meet food safety requirements.	Not all food preparation surfaces promote food safety.	<p>Ensure all work surfaces meet food safety requirements.</p> <p>90 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	Activities were observed during the on-site audit of the facility. Interviews with residents and family confirmed having the opportunity to participate in activities and having choices around their participation. The activities programme includes a variety of activities. Attendance records are maintained. Over weekends residents receive visitors and on Sundays, church goers can attend church services, however, residents who do not have family or friends visiting and those who do not attend church services do not have recreational activities provided.	Not all residents have access to activities over weekends.	<p>The activities programme to provide activities for all residents over weekends.</p> <p>90 days</p>

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.