

Oceania Care Company Limited - Addington Lifestyle Care

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: Addington Rest Home

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

Dates of audit: Start date: 7 May 2019 End date: 8 May 2019

Proposed changes to current services (if any): The facility has applied to add residential disability - physical disability to the service types for certification. On audit day the facility had five residents with physical disability. The audit determined that the facility meets all requirements of care or the safe delivery of physical disability services.

Total beds occupied across all premises included in the audit on the first day of the audit: 92



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

Addington Rest Home (Oceania Healthcare Limited) can provide care for up to 97 residents. Occupancy on the first day of audit was 92.

This surveillance audit was completed against the relevant Health and Disability Services Standards and the service contract with the district health board, including review of policies, procedures, residents and staff files, observations and interviews with residents, family, management, staff and both a nurse practitioner and general practitioner.

There are no areas identified as requiring improvement from the previous certification audit. There were two areas for improvement identified at this surveillance audit, including meeting minutes to evidence corrective action processes where needed and rosters to ensure safe and appropriate staffing.

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 available and accessible to residents and their families on admission, throughout the facility and through resident meetings.

Residents and family interviews confirmed their rights are being met, staff are respectful of their needs and that communication is appropriate.

The complaints register is maintained and up to date. Complaints were reviewed, investigated, processes documented, and outcomes recorded.

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 for Addington Rest Home and responsible for the services provided at this facility. The business plan and quality and risk management systems document the scope, direction, goals, values and mission statement of the facility.

The business and care manager, who has been in the role for 6 years, is responsible for the overall management of the facility and is supported by a clinical manager, registered nurses and the regional and executive management teams.

Service delivery is monitored.

Policies are reviewed and reports to the national support office includes benchmarking and the monitoring of service delivery. There is a quality and risk management system in place, guiding the provision of clinical care and support. Clinical indicators are

benchmarked, and reports include; incidents/accidents, infections and complaints. An internal audit programme is implemented. The service' database is both electronic and hardcopy to record risks. Risks and controls are clearly documented.

There is an incident and accident management system that records and reports all adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting. Records confirmed that staff communicate with residents and family members about incidents.

Recruitment, employment and human resources practices are in line with legislative requirements. Staff and allied health professionals have current practising certificates if they require them. Staff competency is assessed, and a training plan is implemented.

The service has a policy guiding staffing and skill-mix requirements.

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.
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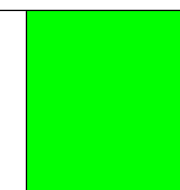
The business and care manager and clinical manager are primarily responsible for entry to service at Addington Rest Home. Residents are assessed prior to entry to the service. Person centred care plans are current and are based on initial assessments, interRAI outcomes and an integrated range of clinical information. Short-term care plans are in place to manage short-term problems. Care plans are reviewed six-monthly or more often as required. Interviews with residents and their families confirmed they are involved in the care planning and review process and are kept up to date with any changes. Handovers and progress documentation guide continuity of care.

The activities programmes are resident focused and include activities that meet the physical, cultural and cognitive abilities and preferences of each resident group. Special consideration and additional activities are provided for younger people with disabilities. Residents are encouraged to maintain community links. Residents and families report satisfaction with the activities programme.

Medicine management occurs according to policies and procedure, in alignment with legislative requirements and consistently implemented using an electronic system. Medications are administered by registered nurses, enrolled nurses and senior health care assistants. Medicine management competencies for staff who administer medicines were current.

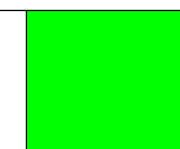
The executive chef is responsible for food service provision. All meals are prepared on site. The food service meets nutritional requirements and individual dietary needs of the residents. There is a current food control plan. All kitchen staff had completed food safety training. Residents and families interviewed confirmed their satisfaction with the food service. There are nutritious snacks available 24 hours.

Safe and appropriate environment

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

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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Restraint minimisation and safe practice policies and procedures are implemented.

The clinical manager oversees restraint minimisation. Staff receive training in restraint minimisation and challenging behaviour management. On the days of audit, the service had four residents using restraint and four residents requesting the use of enablers. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary. Staff interviews confirmed understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The type of infection surveillance is appropriate to the size and complexity of the service. One of the registered nurses' is the infection control nurse. Monthly surveillance is conducted and reported to staff and management. This information is also reviewed by the Oceania Healthcare Limited clinical quality team and reported to the Oceania Healthcare Limited board monthly. Review of surveillance records evidenced infection rates are low and infections are followed up when required.

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	14	0	2	0	0	0
Criteria	0	37	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and procedures are in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>The complaints register records a summary of each complaints, acknowledgements of each complaint, the investigations completed, acknowledgements of all complaints, outcomes and closure of complaints. All complaints reviewed demonstrate resolution and documentation to support closure.</p> <p>Systems are in place to ensure residents and their family are advised of the complaint process and the Code. Complaints forms are displayed for easy access. The complaints process is re-iterated at resident/family meetings. Residents and families interviewed confirmed understanding the complaints process.</p> <p>Resident meeting minutes reviewed confirmed that residents and their families can raise issues of concern during these meetings.</p> <p>There have been no complaints to external agencies since the certification audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	<p>FA</p>	<p>Service information is provided to residents and their families, on admission, as part of the information pack. The resident admission agreement is signed by residents or their representative on entry to the service. The agreement details information about the services that are included in service provision. Monthly resident/family meetings</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>provide information and an opportunity for resident input.</p> <p>Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and families.</p> <p>The residents' files reviewed provided evidence that communication with family members is documented in their records. There is evidence of communication with the nurse practitioner (NP), the general practitioner (GP) and family following adverse events.</p> <p>Residents in the rest home and family members of residents in the hospital and dementia unit stated they know who the key staff are. Interviews with residents and family members confirmed staff communicate with them in an open and transparent manner.</p> <p>Interpreter services are available when required. No residents required interpreter services at the time of the on-site audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Oceania Healthcare Limited's (Oceania) vision, values, mission statement and philosophy are displayed at the entrance to the facility. The Oceania mission statement and philosophy reflect a person/family centred approach for all, including younger persons with disabilities (YPD).</p> <p>The organisation records their scope, direction and goals in business, strategic and quality plans. The business and care manager (BCM) provides monthly reports to the national support office. Business status reports are benchmarked against other Oceania facilities.</p> <p>The BCM has been in this role for about 6 years and has previously worked in aged care management for more than 10 years. The BCM is supported by a clinical manager (CM), who is responsible for clinical matters, and the regional clinical quality manager. During the on-site audit the regional clinical quality manager, who has been in their role for 18 months, was acting BCM as the BCM was on annual leave.</p> <p>The CM is a registered nurse (RN) with a current annual practising certificate. The CM has been in this role for more than two years and was newly appointed to the role at the previous certification audit.</p> <p>The facility can provide care and support for up to 97 residents with 70 beds identified as dual-purpose beds and 27 beds in the dementia unit. During the first day of audit there were 92 residents in the facility; 26 residents receiving rest home, 43 hospital and 23 receiving dementia level of care.</p> <p>The service is certified to provide rest home, hospital and dementia level care. The service has contracts with the district health board (DHB) for the provision of medical care including end of life services; residential non-aged services for YPD and respite services.</p> <p>There were five YPD residents with physical disabilities receiving care; one resident in the rest home and four in the hospital, of which one was for respite care at the time of the on-site audit. Oceania are aware of the need to apply</p>

		for the addition of physical disability services to their certification.
<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>	PA Low	<p>The facility uses the Oceania's documented quality and risk management framework to guide their practice.</p> <p>Organisational policies and procedures are implemented to support service delivery. Policies are subject to review, current and align with good practice. Policies reviews are completed by the national support office, with input from BCMs. Policies are available to staff in hard copy. New and revised policies are presented to staff at staff meetings.</p> <p>Key quality indicators including meeting minutes, incident and accident reports, complaints management and the internal audit programme were reviewed for the role in the quality improvement process. Review evidenced clinical indicators are monitored and quality improvement data is collected. There are monthly combined staff, quality, clinical and health and safety meetings. Meeting minutes evidenced communication with staff regarding all aspects of quality improvement and risk management. All meetings have an agenda and minutes are maintained, however, not all meeting minutes provide evidence of the corrective action process where required.</p> <p>Family, resident and staff satisfaction surveys are completed as part of the annual audit programme. Collated results are compared with previous surveys and actions arising from findings implemented.</p> <p>There is a hazard register identifying health and safety risks, as well as: risks associated with different areas of service delivery and human resource management.</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>	FA	<p>Interviews with the acting BCM and CM confirmed their understanding of the circumstances and events that require the facility to report to and notify statutory authorities, including police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks. There was evidence of the service having notified HealthCERT of the changes that occurred in the business and care management role. Incidents where authorities have had to be notified are documented and held in the relevant file. There was a coroner's investigation into the death of a resident which has now been closed.</p> <p>Staff records demonstrated they receive education at orientation on adverse event reporting processes. Staff interviews confirmed an understanding of incident and accident reporting and their obligation to document untoward events. The service is committed to providing an environment in which staff can recognise and report errors or mistakes.</p> <p>Open disclosure was evident for recorded events. Information gathered is shared at monthly meetings. Trends are graphed and analysed with benchmarking of data occurring with other Oceania facilities.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource policies and processes are in place and implemented.</p> <p>Registered nurses, including the CM, hold current annual practising certificates. Staff files reviewed, included employment documentation such as: job descriptions; contracts; and appointment documentation on file. Police and drug checks are completed, and an annual appraisal process is in place.</p> <p>Newly recruited staff complete the orientation programme, and this was evident in staff files. All staff employed for greater than one year had a current performance appraisal. Newly employed staff have interim appraisals at three and six months after employment.</p> <p>Mandatory training is identified on a company-wide training schedule and occurs in the form of grow, educate and motivate (GEM) study days. A training and competency file is held for all staff. Folders of attendance records and electronic documentation of all training is maintained. The service has a varied approach to ensuring that staff receive annual training that includes attendance at training sessions and annual in-service training around core topics such as: medication; restraint; infection control; health and safety; manual handling and continence. Seven of eight RNs and the CM have completed the interRAI assessment training. The training register and training attendance sheets demonstrated staff completion of annual medication and other competencies such as: hoist; moving and handling; hand washing; wound management and two yearly first aid competency.</p> <p>Health care assistants (HCA) working in the dementia unit complete the required unit standards. There were HCA who were still in the process of completing this training which is supported by Oceania. The service also enrolled HCA and RNs to a dementia series called 'Walking in others' shoes' offered at the Christchurch District Health Board (CDHB). All the staff have engaged/enrolled (RNs as well as HCA's). There are 12 HCA working in the dementia unit. The data provided to us confirmed that all HCAs are enrolled in dementia training and that there are five HCAs who have completed the DHB training, two are currently on the course and four are on the waiting list. Regarding the unit standards for dementia training four of the HCAs have completed level four aged care training including the dementia care unit standards, two have completed the dementia level four training, two are currently enrolled and in the process of completing the course and four are new (within the six month timeframe for starting the course) and they are all in the process of enrolling with the applications have been sent. One of the HCAs also previously completed the ACE dementia care. All of the four new staff have completed induction and orientation to the dementia unit including buddying with senior HCAs.</p> <p>Staff are also attending another course; relating palliative care, including; the 'Te Ara Whakapire' series for HCAs.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	<p>PA Low</p>	<p>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.</p> <p>Rosters reviewed, interviews with residents, family and staff confirmed that staffing does not consistently meet the</p>

<p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>needs of residents. Residents requiring rest home level of care were encouraged to be as independent as possible. The CM and senior RNs provide 24-hour, on-call support for clinical matters.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medicine management system is documented and implemented and complies with legislation, protocols and guidelines.</p> <p>Medications are checked against the resident's medication profile on arrival from the pharmacy by a RN. Any errors by the pharmacy are regarded as an incident and referred back to the pharmacy. Weekly checks and six-monthly stocktakes are conducted and confirmed that stock matched expected levels. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are stored in line with current legislation, protocols and guidelines. Review of the medication fridge confirmed that the service does not store or hold vaccines. The medication refrigerator temperatures are monitored and maintained within the required range.</p> <p>An electronic medication management system is used at the facility and meets the current legislative requirements and safe practice guidelines. Medication administration observed met legislative requirements. Three-monthly medication reviews are conducted by the GP and any discontinued medicines are managed as required.</p> <p>Staff attend annual medication education. Staff administering medicines, including RNs, enrolled nurses (ENs) and senior HCAs, have completed medication competencies as evidenced in staff files sampled.</p> <p>One rest home resident was noted to be self-administering medications during the on-site audit days. The required competencies for this resident were completed and medicines were safely stored. There is a policy and process that describes self-administered medicines. Younger persons are supported to self-administer medicines where appropriate. There were no standing orders in use at time of audit.</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</p>	<p>FA</p>	<p>The executive chef (EC) oversees food provision at Addington. 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.</p> <p>Food in the chiller was observed to be covered and dated. The kitchen was clean and all food was stored off the floor.</p> <p>There is a four weekly seasonal menu approved by a dietitian at organisational level. Diets are modified as required. At interview, the EC reported the RN completes each resident's nutritional profile on admission with the aid of the resident and family. The EC is made aware of any changes. Special diets and cultural considerations are catered for</p>

<p>component of service delivery.</p>		<p>and documented in the kitchen. Special equipment, to meet residents' nutritional needs, is readily available. Meals are delivered straight to residents in the two adjacent dining rooms via a bain-marie and hot box to the hospital dining room to maintain correct food temperatures. A tray service is provided. Food temperatures are monitored. Residents requiring extra support to eat and drink are assisted and this was observed during lunchtime at the on-site audit.</p> <p>Food audits are carried out as per the yearly audit schedule.</p> <p>The service encourages residents to express their likes and dislikes and the EC seeks feedback from residents at dining times. Residents and families reported satisfaction with the food service provided.</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>	<p>FA</p>	<p>In files sampled wound care plans, nutrition management, skin integrity management, medical specific plans, pain management and falls prevention plans were evident where required. There was evidence of referrals to specialist services such as: podiatry; physiotherapy; speech language therapist; dietitian and wound specialist nurses. The use of short-term care plans was evident for short-term problems.</p> <p>Nursing progress notes and observation charts are maintained. Family communication is recorded in the residents' files. Interview with the GP confirmed they provide 24-hour, 7 day a week support. Medical records identified reviews are completed at least monthly or more frequently if needed. The GP and NP interviewed spoke positively about the service and reported the RNs refer any concerns in a timely manner and instructions are implemented.</p> <p>There were sufficient supplies of products and equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p> <p>Staff interviews confirmed they are familiar with the needs of the residents they are allocated to. In interviews residents and family members reported that residents' individual needs were appropriately met and they were actively involved in planning of care.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture,</p>	<p>FA</p>	<p>The diversional therapist (DT) and activities co-ordinator (AC) provide an activities programme which aims to address the residents' needs, age and cultural preferences. The AC has undertaken training in challenging behaviour management and de-escalation. There are two separate programmes, one for rest home and hospital and one for residents with dementia delivered Monday to Friday. Activities are available for the residents over the weekend supported by the HCAs. The programmes are made available to all residents and their families. The DT interviewed explained the variety of the programme, community involvement and the inclusion of exercise activities and activities of resident choice. Activities provided reflect ordinary patterns of life and include, but not limited to, games, entertainers, crafts, exercise classes, singing and weekly van outings. The service had younger persons' with specific care plans including additional social activities and community links to meet their specific needs. There is a specific weekly van outing for younger residents to accommodate shopping, banking and other needs. On the</p>

<p>and the setting of the service.</p>		<p>day of audit, residents including younger persons, were observed being actively involved with a variety of activities. Some residents attend activities of interest in the community. Residents who prefer to stay in their room can have one-on-one visits including, for example, reading, hand massage and music.</p> <p>Residents have an assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career and family. There is a 24-hour behavioural activity plan completed for residents with dementia. Residents in dementia care have additional activities to help manage behaviour over 24 hours. Attendance records are maintained. The activities monthly progress reports are entered in the residents' clinical files and record outcomes against goals. Resident files reviewed identified that the individual activity plan was reviewed at least six monthly.</p> <p>Residents and families interviewed commented positively on the activity programmes provided.</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>There was documented evidence that RN evaluations were current and completed for all care plans sampled. Files sampled evidenced at least six-monthly care plan reviews were completed. Reviews include the degree of achievement towards meeting desired goals and outcomes. Resident care is evaluated on each shift and reported in the residents' progress notes. If any change is noted it is reported to the RN or the CM.</p> <p>A short-term care plan is initiated for short-term concerns, such as infections and wound care. Interviews verified residents and family/whānau are included and informed of all changes.</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>The building warrant of fitness is current and displayed in the facility. There had been no structural changes to the facility since the previous audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p>	<p>FA</p>	<p>The Oceania Healthcare Limited surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed. One of the RNs is the infection control nurse (ICN). Infection data is collated monthly by the ICN and CM and is submitted to Oceania national support office where benchmarking is completed. This data is analysed for trends and reported at the monthly infection control meeting and at the monthly staff and quality meeting for all staff.</p>

with agreed objectives, priorities, and methods that have been specified in the infection control programme.		Interview with the CM confirmed there had been one outbreak of since the previous audit. Review of documentation evidenced this was managed and reported as required.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The Oceania Healthcare Limited restraint minimisation and safe practice handbook and policies comply with legislative requirements. The restraint coordinator is the CM. A signed position description was sighted. The Oceania clinical and quality team are responsible for approving any form or type of restraint practice used at Oceania facilities nationally. Restraint is only used as last resort once all alternative strategies are considered. Enablers are voluntary and the least restrictive option is in use to maintain resident independence and safety. The restraint register is maintained and current. There were four residents using restraint and four residents using enablers during the on-site audit days. The required documentation relating to restraint was recorded.

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>The quality systems and process review included incident and accident records, internal audit processes, complaints management processes and meeting minutes.</p> <p>Corrective action plans are developed and closed out for incident and accident processes. Corrective actions are implemented for areas requiring corrective actions in the internal audit programme and the complaints management process. The corrective action processes for issues requiring improvement from meeting minutes are not consistently recorded. Meeting minutes do not consistently document the required corrective action, person responsible for the implementation of change timeframes for implementation or the sign-off of corrective actions.</p>	Requirements for improvement as identified in meetings are not always documented and managed through a corrective action process.	<p>Ensure requirements for improvement identified in meetings are managed using the corrective action process.</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>	<p>PA Low</p>	<p>During review of a roster stretching over a two-week pay-period it was found that the service implemented 'flexi' shifts where there is no staff allocated for service delivery. This shift is left blank for staff (who are often already rostered for eighty hours over the fortnight) to pick up the shifts.</p> <p>Week one showed six HCA morning shifts in the hospital were not covered. In week two, five HCA morning shifts were not covered. There was evidence of some staff working back-to-back shifts (16 hours).</p> <p>The service is using a template with a shift called the 'flexi-shift' throughout all rosters. The flexi shifts are not completed with allocated names of staff but left open for staff to pick up as additional hours. Where staff do not pick these hours up as overtime the shift may work short, as confirmed in staff and family/resident interviews.</p> <p>Review of the payroll over 2 weeks showed that 18 staff worked over-time of which 10 worked more than 10 hours.</p> <p>This data, with feedback from residents, family and staff evidenced that there were staff shortages and there is a requirement for improvement to ensure safe services.</p>	<p>Rosters do not currently facilitate appropriate safe care for residents.</p>	<p>Rosters to ensure appropriate safe care for residents.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.