Oceania Care Company Limited - Addington Rest Home

Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Oceania Care Company Limited
Premises audited:	Addington Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 5 August 2020 End date: 6 August 2020

Proposed changes to current services (if any): Audit included review of reconfiguration of five dual purpose beds to five residential disability-physical beds. The total number of beds remains the same at 97.

Total beds occupied across all premises included in the audit on the first day of the audit: 93

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 is owned and operated by Oceania Healthcare Limited and provides rest home, hospital, dementia and residential disability-physical care for up to 97 residents. Occupancy on the first day of audit was 93.

This certification audit was conducted against the relevant Health and Disability Services Standards and the services contracted by the district health board. The audit process included a review of policies and procedures, a review of residents' and staff files, observations and interviews with residents, families, management, staff, a nurse practitioner and a general practitioner.

Areas identified as requiring improvement relate to planned activities, medication management and facility specifications.

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.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights on admission and these are respected. Services are provided that support personal privacy, independence, individuality and dignity.

Residents who identified as Māori have their needs met in a manner that respects their cultural values and beliefs. The residents' cultural, spiritual and individual values and beliefs are assessed on admission.

Open communication between staff, residents and families is practiced and confirmed to be effective. There is access to interpreting services if required. Informed consent is practised, and written consent is gained when required.

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

The facility has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Oceania Healthcare Limited is the governing body responsible for the services provided at the facility. The vision, mission and values of the organisation are documented and communicated to all concerned.

An experienced business and care manager oversees the facility with the support of a regional operations manager. A qualified clinical manager supervises the clinical services supported by a regional clinical and quality manager present at the time of audit. Both the facility manager and the clinical manager are registered nurses with current practicing certificates.

The facility adheres to Oceania Healthcare Limited quality and risk management systems for the ongoing monitoring and improvement of services delivery and risk mitigation. All data collection and reporting follows a schedule. Meetings are held to discuss key clinical performance indicators, quality and risk issues, residents' satisfaction, and corrective actions to implement and review.

Human resource management processes follow legislated guidance and organisation staffing policy. Staff are appropriately appointed, orientated and educated to deliver services to the facility residents.

A roster model with skill mixes, service types and occupancy levels guides the workforce planning to cater for the residents twenty-four hours a day, seven days a week.

Resident information is accurately recorded, securely stored and protected from unauthorised people.

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.

Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after admission.

The interRAI assessment is used to identify residents' needs; these are completed within the required timeframes. The general practitioner completes a medical assessment on admission and reviews occur thereafter on a regular basis.

Person centred care plans are developed and implemented within the required timeframes, they are individualised and based on an integrated range of clinical information. Residents' needs, goals and outcomes are identified. All residents' files reviewed demonstrated evaluations were completed at least six-monthly. Residents and their relatives are involved in the care planning process and notified regarding any changes in a resident's health status.

Short-term care plans are in place to manage short-term issues or problems as they arise. Handovers between shifts guide continuity of care and team work is encouraged.

An electronic medication management system in place. Medication management is in line with the legislation and contractual requirements. Medications are administered by registered nurses and health care assistants who have completed current medication competency requirements.

The activity programme is managed by a diversional therapist with assistance from an activity coordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The service uses its facility van for outings in the community. Family are able to participate in the activities programme.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control plan. Kitchen staff have food safety qualifications.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

There is a current building warrant of fitness. A reactive and preventative maintenance programme is implemented. External areas are accessible, safe and provide shade and seating.
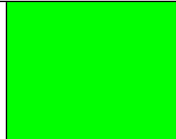
Residents bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids and the provision of cares. Lounges, dining rooms and sitting alcoves are available for residents and their visitors. Communal and individual spaces are maintained at a comfortable temperature.

A call bell system is available to allow residents to access help when needed.

Security systems are in place with regular fire evacuation procedures completed.

Processes to manage waste and hazardous substances are implemented. Protective equipment and clothing is provided and used by staff. The facility's laundry is conducted off site, apart from some residents' personal items which are laundered on site. Cleaning of the facility is conducted and monitored by household staff.

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.

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse. On the day of the on-site audit, two restraints and three enablers were in use. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary.

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 is appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Oceania Healthcare National Office.

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	47	0	0	3	0	0
Criteria	0	98	0	0	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies, procedures and processes are in place to meet the obligations in relation to the Code of Health and Disability Services Consumers Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included in the staff orientation process and part of ongoing training and was verified in training records sighted.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form that includes consent for photographs, outings and collection and sharing of health information. Consent is also obtained on an as required basis, such as for influenza vaccinations. There was evidence of advanced directives signed by the residents. Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members reported they were kept informed about what was happening with their relative and consulted when treatment changes were being considered.

		Staff were observed gaining verbal consent for day to day care.
Standard 1.1.11: Advocacy And Support

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on the NHDAS is included in the staff orientation programme and in the ongoing education programme for staff. Staff demonstrated understanding of the NHDAS, with contact details for NHDAS readily available at the facility.

During the admission process, residents are given a copy of the Code and the facilities handbook, which also includes information on the NHDAS. Posters and brochures related to the NHDAS were also displayed and available in the facility. Family members and residents interviewed confirmed awareness of the NHDAS, how to access this and their right to have support persons. |
| 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 | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.

The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management

The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The right for residents and families to make a complaint is defined by a policy that aligns with right 10 of the Code. The complaint process is explained at the time of admission. Interviews with residents, families and enduring power of attorneys (EPOAs) confirmed that they know how to make a complaint and that they are guided by the written information provided by the facility.

Complaint forms, and a secure complaint and compliment box were sighted at the entrance to the premises. All complaints reviewed through documentation were managed according to policy in the required timeframes. The BCM is responsible for the complaints' management and follow up.

A complaint register is available that lists the complaints received, including written, verbal and anonymous complaints. The observed register is current and contains dated evidence of the complaints' communication, investigation and resolution.

Interview with the BCM advised that there had been no complaints made to external agencies since the previous audit. |

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	During the admission process, new residents are given a copy of the Code and the facility handbook which includes information on the Nationwide Health and Disability Advocacy Service (NHDAS). Posters on the Code are displayed at the reception area along with information on advocacy services Residents and family members interviewed were familiar with the Code and the NHDAS. Residents and family members interviewed stated they would feel comfortable raising issues with staff and management.
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	Staff were observed to maintain resident privacy throughout the audit. All residents have a private room, with one married couple sharing two rooms. Residents are encouraged to maintain their independence by participating in community activities and outings, confirmed at residents and family interviews. Residents care plans include documentation relating to residents' abilities and strategies to maximise independence. Residents records sampled confirmed that residents individual cultural, religious, social needs, values and beliefs were identified, documented and incorporated into their care plan. The policy on abuse and neglect was understood by staff interviewed, including what to do should there be any signs of abuse and/or neglect. Education on abuse and neglect is part of the staff orientation programme and is included in mandatory staff study days. Interviews with residents and families confirmed that residents receive services in a manner that has regard for their dignity, privacy, spirituality and choices.
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	The service has a Māori Health Plan that guides staff in meeting the needs of the residents who identify as Māori. Any additional cultural support, if required would be accessed locally. This was confirmed during an interview with the business and care manager (BCM). Review of clinical files and interviews confirmed individual cultural needs were being met. Residents and their whānau/family interviewed reported that staff acknowledge and respect their individual cultural needs. Staff interviewed demonstrated knowledge of individual residents and whānau/family cultural values and beliefs, as well as the significance of whānau/family involvement.
Standard 1.1.6: Recognition And	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff

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.		respected these. Residents' personal preferences, required interventions and special needs were included in care plans reviewed.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses (RN) have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Addington Rest Home implements Oceania Healthcare Limited (Oceania) policies and procedures which are based on good practice, current legislation and relevant guidelines. The service encourages and promotes good practice through evidence-based policies and procedures, input from external specialist services and allied health professionals such as, the palliative care nurse specialist, physiotherapists, and staff specialised portfolios such as wound care management. Other examples of good practice observed at the audit included the buffet style breakfast that residents may access or if preferred a tray service will be provided. Along with a coffee machine that dispenses a variety of coffees at any time for residents and family.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Interviews with residents and families evidenced that the BCM has an open-door policy and is approachable to answer any concerns or questions that arise. The organisation's open disclosure policy sets the process to follow when adverse events affect residents' care. Review of accidents/incidents documentation showed that residents and families are notified of untoward events in a timely manner and receive an apology for undesirable situations. Clinical staff interviewed keep residents and families updated of changes to resident status and encourage participation in care planning.

		Residents and families are invited to take part in residents' meetings that occur monthly as seen in minutes. Meetings' discussion and outcomes are communicated through handouts.
		Residents' needs for interpreting services are discussed at the time of entry to services. Access to interpreters is organised through families or the district health board (DHB). Specific care arrangements made by staff for people with communication impairments are observed.
Standard 1.2.1: Governance

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Addington Rest Home is part of Oceania with the board, board committees, and executive team providing direction and support to the service. The organisation has vision, mission and values' in place which are resident centred. The organisation values were displayed in the foyer of the facility. The BCM develops annual objectives for the quality of service delivery, performance and risks at a facility level. Objectives approved by the head office were sighted in the facility's business plan. The BCM reports monthly to a regional operations manager on key performance indicators.

The BCM has been in the role for seven years and had prior management experience in community nursing and support services. The clinical manager (CM) has worked in the facility for three years in this position and has performed similar roles for other providers in the past. Both managers have current RN practicing certificates and maintain their knowledge of the sector through representation and participation in aged-cared forums and seminars.

The service provides dementia, hospital and rest home care for up to 97 residents. The facility is certified for 28 dementia level beds, 5 residential disability-physical and 64 dual-purpose beds. Twenty-two of the dual-purpose beds were available as occupation right agreements (ORAs).

At the time of the audit, there were a total of 93 residents in the facility: 28 receiving dementia care, 34 receiving hospital level care, and 31 receiving rest home level care including 19 with ORAs. Contracts with the DHB were sighted for aged-related care, support cares to end of life and severe medical illness, respite care, and young people with physical disability (YPD). Included in total occupancy numbers were five residents under the YPD agreement assessed at hospital level care. |
| Standard 1.2.2: Service Management

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and | FA | Short-term absence of the facility BCM is covered by the CM. A relief manager is organised by the regional management team to ensure the day-to-day operations of the facility in case of extended leave. The CM is supported by senior RNs in leadership roles, who can help cover leave if necessary. The regional clinical and quality manager (CQM) assists the CM as needed and was observed doing so during the audit. |

safe services to consumers.		
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.	FA	The organisation's quality improvement policy and audit plan support a quality and risk management system that promotes collaboration between the senior management team, regional and facility managers, CMs, staff, and residents. The aim is to monitor and implement continuous quality improvement within the organisation. Addington Rest Home uses a range of audit and survey data to benchmark its service against other facilities' and to inform plans that can improve quality and mitigate risk. The facility adheres to Oceania organisation-wide policies and procedures that are current. A document control policy is in place. Key components of service delivery are captured through clinical indicators, accidents/incidents, complaints, registration of hazards and risks, internal audits, residents' satisfaction, and they inform the quality management system. Quality data is systematically collected according to planned schedules for internal audits, clinical indicators, residents' evaluation surveys and continuous improvement projects. Young people with physical disabilities satisfaction is captured through patient and family evaluation surveys. Results are charted, analysed, evaluated, and shared with staff and residents in meetings and committees as verified through minutes. Summative evaluations and alerts are circulated electronically to staff or accessible as hard copies sighted on bulletin boards. A focus on quality monitoring, reporting and outcomes was evident in the facility operational and business brief. Quality goals and achievements are discussed in monthly quality improvement and staff meetings, with minutes accessible to staff on notice boards. Interview with the CM and meeting minutes confirmed that clinical issues and successes on key performance indicators by service type feed into discussion at bi-monthly RN meetings. Relevant corrective actions are developed and implemented to address any shortfalls, with evaluation of actual improvement carried out in the following reporting period. Quality improvement data sighted evidenced that data is being collected and collated with the identification of trends and analysis of data. Corrective action plans are developed, implemented, evaluated and documented. There is communication with staff of any subsequent changes to procedures and practice through meetings, available minutes and various personal communication methods. A current hazard register identifies health and safety risks and risk ratings associated with different areas of the environment, service delivery and human resource management. The health and safety committee meet monthly to review findings and action plans which include a person responsible for the corrective action, a timeframe, and an evaluation of the improvement outcomes.

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.	FA	The BCM is aware of situations in which the service is required to report and notify statutory authorities. The BCM advised there has been no required notifications to the Ministry of Health or other statutory authority since the last audit. Staff interviewed are aware of the organisation policies and processes regarding the reporting, the notification and the management of adverse events affecting residents. Incident/accident electronic records reviewed demonstrated that staff document adverse events and near misses, and notify the resident, family/EPOA, general practitioner (GP) and medical emergency services when necessary. Staff interviewed commented that the facility supports the reporting and recording of unanticipated events and errors. This was observed in the communication documents addressed to staff. The CM is responsible for reviewing clinical accidents/incidents and for developing corrective actions that mitigate the future risks. The CM produces reports and analysis of accidents/incidents data that were sighted. The reports inform quality improvement initiatives in the facility and quality plans at a regional and national level.
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	Human resources management follows an existing staffing policy which adheres to the principles of good employment practice and the Employment Relations Act 2000. Staff files reviewed evidenced that the recruitment process was implemented as per policy and involves referee checks, police vetting, and a signed employment contract against a job description. The infection prevention and control (IPC) coordinator has a role specific job description. Sample of staff records illustrated that employees are qualified for their role and where required have a current practicing certificate. A copy of a current driver's licence is obtained for all drivers of the van. The restraint coordinator completes specific qualifications to fulfil this role. Staff files contain induction/orientation checklists with essential components for the role. Staff confirmed the orientation and training programmes support their capacity to deliver services for the residents. Review of documented staff appraisals showed they occur at least yearly. Continuous professional development takes place through an annual education calendar, which includes education relevant to people with physical disability. A mix of monthly pre-booked and open sessions depending on individual training goals was discussed with the BCM. All staff are enrolled to complete a minimum eight hours of regulatory annual training provided by the wider Oceania organisation. The CM recognises and organises additional health care education based on quality reviews and gap analysis. An electronic database enables the ability to log, identify and plan staff training and relevant core competencies updates. Records reviewed demonstrated that training occurs as planned.

		Twelve of thirteen RNs are qualified to asses interRAI. Health care assistants (HCA) who work in the dementia unit were verified to have undertook the necessary education credits in the required timeframes.
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 BCM uses a pre-populated roster template to predict the number of full time equivalent (FTE) hours and staff mix required to deliver residents' care 24 hours a day, 7 days a week (24/7) for each service type based on occupancy. A review of rosters showed adequate staff cover 24/7, with at least one RN supporting the hospital level residents at all times, and one staff member with a current first aide certificate on duty in each facility wing across all shifts. Absent staff are replaced by on-call/casual employees and agency staff are only occasionally used in the reviewed rosters. The BCM confirmed ongoing recruitment of casual staff is ensured to mitigate staffing variances. In the morning Monday to Friday there are three RNs and nine HCAs allocated to the two mixed rest-home/hospital wings; and one RN and four HCAs allocated to the dementia unit. In the afternoon, two RNs and eight HCAs are rostered in the two mixed rest-home/hospital wings. The dementia unit shares an RN with the less acute hospital wing but has its own three HCAs. In the night one RN works across the two rest-home/hospital wings and assists the dementia wing as required. At night there are three HCAs in the rest-home/hospital wings and two HCAs in the dementia wing, including one medication competent HCA. The weekend mornings have two RNs in the facility, one shared between the less acute rest-home/hospital wing and the dementia wing, and one who focuses on the more acute rest-home/hospital wing. Other staffing allocation remains the same than during week days. The ORAs are incorporated into the existing dual purpose bed configuration. Non-clinical staff rostered seven days a week include kitchen employees, laundry personnel, cleaners, a diversional therapist and activity coordination team. There is access to a podiatrist and physiotherapist. Residents and families reported adequacy of staff levels and skills to complete the required cares and services in a timely manner. The CM and BCM are on call 24/7 to support the facility with emergency matters.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and	FA	Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals. Records were legible with the name and designation of the person making the entry identifiable. Residents files reviewed included relevant information on the residents' care and support information that could be accessed in a timely manner. There are policies and procedures in place to ensure privacy and confidentiality. Staff interviews described the procedures for maintaining confidentiality of residents' records. Residents files are

accessible when required.		maintained securely. No personal or private resident information was on public display during the audit. Electronic data is password protected and can only be accessed by designated staff. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the electronic database.
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 (NASC) assessments are completed for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. There is a comprehensive information pack provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service processes, ensuring compliance with entry criteria. Interviews with residents and family and review of records confirmed the admission process was completed by staff in a timely manner. Residents and family members interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Transition, exit, discharge or transfer is managed in a planned and coordinated manner. Interviews with RNs and review of residents' files confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers. A transfer form accompanies residents when a resident is moved to another service or facility. 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.	PA Moderate	A current medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Aged Residential Care. A safe system for medicine management using an electronic system was observed on the days of audit. Prescribing practices in line with legislation, protocols and guidelines were observed. The required three-monthly reviews by the GP were recorded electronically. However, resident allergies and sensitivities were not consistently documented on the electronic medication chart. The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing orders used at the facility. Review of the medication fridge evidenced that the service does not store or hold vaccines, interviews

		with the RN confirmed this. The medication refrigerator temperatures are monitored weekly.
		Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks and six-monthly stocktakes of medications are conducted in line with policy and legislation.
		At interview staff demonstrated understanding of their roles and responsibilities related to each stage of medication management process. Staff observed, administering medication demonstrated knowledge and complied with the medicine administration policies and procedures. The RNs oversee the use of all pro re nata (PRN) medicines and documentation records, noting effectiveness on the electronic medication record. Progress notes were sighted. Current medication competencies were evident in staff files.
		There were two residents self-administering medication during the on-site audit. Safe storage was provided and sighted. A process is in place to ensure ongoing competency of the residents. Self-medication is authorised by the GP.
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	All meals are prepared on site and served in the dining rooms or in the resident rooms if requested. The seasonal menu has been reviewed by a dietitian, with the winter menu implemented at the time of audit. The food control plan is current. Food management training and certificates for cooks and kitchen staff were sighted.
		Food temperatures are monitored appropriately and recorded. The kitchen staff have relevant food hygiene and IPC training. The kitchen was observed to be clean and the cleaning schedules sighted.
		A nutritional assessment is undertaken for each resident on admission by the RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident's dietary needs change. Kitchen staff are also notified when dietary profiles are reviewed, this occurs six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning.
		Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. There were sufficient staff to ensure appropriate assistance was available. Residents and families interviewed stated that they were satisfied with the meals provided.
		All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and cool store. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food

		supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	The service has a process in place if access is declined. When residents are declined access to the service, residents and their family/whānau, the referring agency and GP are informed of the decline to entry. The resident would be declined entry if not within the scope of the service or if a bed is not available. A waiting list is maintained.
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 admission. The initial care plan guides care for the first three weeks. RNs complete the interRAI assessment within the required timeframes. The long-term care plan is based on the interRAI assessment outcomes. Assessments are recorded, reflecting data from a range of sources, including: the resident; family/whānau; the GP and specialists. Policies and protocols are in place to ensure continuity of service delivery. Assessment tools are reviewed at least six-monthly, including falls, dietary, pressure injury and continence. Interviews with residents and families confirmed their involvement in the assessments, care planning, review, treatment, and evaluation of care.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Person centred care plans are developed with resident and family/whānau involvement. All residents' files sampled had an individualised long-term care plan. Person centred care plans describe interventions in sufficient detail to meet residents' assessed needs. Short-term care plans are developed for the management of acute problems. Resident files are managed using an electronic system. Resident files showed service integration with clinical records, activities notes, and medical and allied health professionals' reports and letters. Interviews with residents confirmed that they have input into their care planning and reviews, and that the care provided meets their needs. Review of residents' records showed that the residents under the YPD contact are involved in care planning. Their plans included activities to ensure their wellbeing, community participation and interventions to meet their physical, health and wellbeing needs.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Person centred care plans are completed by the RN and based on the assessed needs, desired outcomes and goals of residents. Interventions are reviewed within required timeframes. The GP documentation and records reviewed were current. Interviews with residents and families confirmed that care and treatment met residents' needs. Staff interviews confirmed they are familiar with the needs of all residents in the facility. Family communication is recorded in the residents' files. The nursing progress notes and observations are recorded and maintained. Wound assessments, treatment and evaluations were in place on the electronic database. Scheduled change of dressings and evaluations had been completed. Adequate dressing supplies were sighted. The RNs could describe access to the DHB wound nurse as required. Continence products are available and resident files included urinary continence assessment, bowel management and continence products identified for day use, night use and other management.
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.	PA Moderate	The residents' activities programme is implemented by a diversional therapist who is assisted by an activities coordinator. Activities for residents are provided 6 days a week, Monday to Friday 9 am to 5 pm and on Saturday 9 am to 1 pm. The programme is run in three different areas of the facility with some activities being communal. On Sunday a range of activities are made available for residents, staff and family to access. The activities programme is displayed on the resident noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural, spiritual and community events. Van outings into the community are arranged twice a week for the residents living in the rest home and hospital. The residents living in the secure dementia wing have a van outing once a week. The residents under the YPD contract are included in the activities programme and they confirmed that they were satisfied with activities that were provided. Additional activities are facilitated to maintain their family and community links for example trips to their family homes and to meet with friends. The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on the residents' interests, family and previous occupations is gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed six-monthly at the same time the care plans are reviewed and are part of the formal six-monthly multidisciplinary review process. All residents living in the secure dementia wing have a behaviour assessment on admission. There are interventions in the PCCP to address challenging behaviour including the use of individual one-on-

		one time and activities. However, there was no specific 24-hour activity plan in place as per Oceania policy to guide staff to address resident challenging behaviour throughout a 24-hour period. The required 'Behaviour that Challenges Activities chart' was not in place for the residents living in the secure dementia wing.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN. Person centred care plans are evaluated every six months in conjunction with the interRAI re-assessments or if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Residents and families interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident's records and documented in the individual resident files reviewed.
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. Where needed, referrals are sent to ensure other health services, including specialist care is provided for the resident. Referral forms and documentation are maintained on residents' files. Referrals are regularly followed up. Communication records reviewed in the residents' files, confirmed family/whānau are kept informed of the referral process.
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	There are policies and procedures in place for the management of waste and hazardous substances. There is an external supplier of chemicals who provides training and education on the use and handling of all chemicals. Safety data sheets were available and accessible for staff. Staff reported they had received training and education to ensure safe and appropriate handling of waste and hazardous substances. There is provision and availability of protective clothing and equipment, and staff were observed using this correctly and appropriate to the risks involved.

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate	A current building warrant of fitness is displayed. There is a preventative and reactive maintenance programme in place to ensure the physical environment and facilities are fit for their purpose. Staff were observed to ensure the environment is hazard free, that residents are safe, and independence is promoted. For example, by the removal of equipment such as linen trolleys and cleaning equipment. The maintenance staff member is supported in their role by a regional maintenance manager. Resident, staff and family interviews, as well as observation/inspection confirmed that personal equipment is available for YPD for their own use. This not used for other residents. The testing and tagging of electrical equipment is completed on-site by a trained maintenance staff member, with the testing and calibration of biomedical equipment completed by an external contractor. The calibration of biomedical equipment and monitoring of refrigeration temperatures is an area identified as requiring improvement. External areas are safely maintained and are appropriate to the residents' groups and setting. Residents confirmed they know the process they should follow if any repairs or maintenance is required, any requests are appropriately actioned and residents are happy with the environment.
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	All but two rooms have ensuites, with two rooms sharing an ensuite. Appropriately secured and approved handrails are provided in the ensuites and other equipment/accessories are available to promote resident independence. There are an adequate number of communal toilets. Separate toilets are available for staff and visitors. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Communal toilets have a system that indicates if they are vacant or occupied. Hot water temperatures are monitored monthly. When hot water temperatures are above the recommended safe temperature, action is taken and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Two adjacent rooms are shared by a married couple, with one room designated as the bedroom and the other a private lounge area. All rooms are of a size that allows for the use of mobility equipment should this be required. Rooms are personalised with furnishings, photos and other personal items displayed

		There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.
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, activity, and dining needs.	FA	There is adequate access to lounges, dining areas and sitting areas/alcoves. Residents were observed moving freely within these areas. Residents interviews confirmed there are alternative areas available to them if communal activities are being run in lounges and dining rooms and they did not wish to participate in them. There is a whānau room which is also used by the GP, if required for family meetings.
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	Cleaning and laundry policies are available. Linen and residents personal clothing are laundered off site at another Oceania facility. Interview with the BCM and household staff member confirmed residents' personal clothes such as woollen items are laundered on-site. There is a dirty to clean flow provided in the laundry. The BCM described the management of laundry including the transportation, sorting, storage laundering and the return of clean laundry to residents. The BCM discussed an ongoing issue was related to missing residents clothing. A new system has been implemented which includes a new labelling system of all residents clothing items, to date this has been more successful with a limited number of items going missing. Investigations noted that these items had not been given to staff for labelling. The cleaner described the cleaning processes and the use of chemicals for cleaning purposes. There are safe and secure storage areas for cleaning equipment and chemicals and staff have access to these areas as required. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility with alcohol gels in various locations.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the Fire and Emergency New Zealand (FENZ). A trial evacuation takes place six-monthly with a copy sent to the FENZ, the most recent conducted in May 2020. The orientation programme includes fire and security training. According to completed education documents all staff are trained in fire safety. Staff confirmed their awareness of the emergency

		procedures.
		There is emergency lighting, gas barbeques for cooking, emergency water supply, blankets available in case of emergency. Emergency equipment accessibility, storage, and stock availability to the level appropriate to the service setting.
		Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.
		Staff interviews confirmed security systems are in place and staff are aware of security processes. Doors and windows are locked at a predetermined time
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	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light provided by opening external windows. Heating is provided by fan heaters in residents' rooms and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit. Residents and families confirmed the facility is maintained at a comfortable 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	Addington Rest Home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an IPC programme. An RN is the infection control nurse (ICN) and has access to external specialist advice from the DHB ICN. A documented role description for the ICN, including role and responsibilities, is in place. The IPC programme is appropriate for the size and complexity of the service. The IPC programme is reviewed annually. Staff are made aware of new infections through daily handovers on each shift, progress notes and clinical records. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of	FA	The ICN is responsible for implementing the IPC programme and is supported by the CM. There is an IPC committee which is made up of staff members from each work area. The committee meets monthly. The ICN has completed training for the role through the Ministry of Health (MOH) online training course. The DHB ICN visits the facility to provide education and advice. The ICN stated that there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's quality meetings. The ICN has

the organisation.		access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the IPC programme.
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 policies and procedures in place that reflect current best practice relating to IPC.

Staff observed were complying with the IPC policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions. Staff were also able to locate policies and procedures. |
| Standard 3.4: Education

The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | All staff attend IPC training. Staff education on IPC is provided by the ICN at orientation and monthly at the quality meetings. Health care assistants and RNs receive further training at their Oceania study days and from external IPC specialists. Records of attendance are maintained. Staff interviewed confirmed that education on IPC is provided by the ICN at orientation and monthly at quality meetings.

Education with residents, when possible, is generally on a one-to-one basis and includes reminders about handwashing, remaining in their room if they are unwell, and increasing fluids during hot weather. There is information regarding IPC and Covid-19 displayed on the noticeboards. Staff receive notifications and updates about IPC via the electronic system, noticeboards, meetings and at handovers. |
| Standard 3.5: Surveillance

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Oceania surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed.

Short-term care plans are developed to guide care and evaluate treatment for all residents who have an infection. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. Families are updated by phone, email or text if required.

Surveillance data is collected in the clinical areas and collated monthly by the CM and forwarded to |

		the Oceania national office for benchmarking. Information following monthly infection data collection and benchmarking is provided to staff through quality and staff meetings, on the staff noticeboard and via the electronic system.
		There have been no outbreaks since the previous audit. The ICN has implemented a pamphlet outlining equipment to be set up in the event of an outbreak and has developed a staff education resource box for IPC.
		Covid-19 information is available to all visitors to the facility. Oceania information including MOH information was available on site. There are adequate IPC resources available should a resident infection or outbreak occur. There is an antimicrobial use policy.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the CM, who provides support and oversight for enabler and restraint management in the facility. The CM is conversant with restraint policies and procedures.
		On the day of the audit, two residents were using restraints (bedrails). Three residents were using enablers (bedrails) which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for any restraint use.
		Restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of restraint minimisation. A review of restraint and enabler use is completed and discussed at all quality and clinical meetings.
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 restraint approval process is described in the restraint minimisation policy. The restraint coordinator is the CM with a job description that defines the role and responsibility of the restraint coordinator.
		An assessment and management process is followed for the use of both restraints and enablers which ensures the ongoing safety and wellbeing of residents. This includes cultural considerations. The restraint coordinator explained the process for determining approval, for recording, monitoring and evaluating any restraints or enablers used. Family/whānau approval is gained should any resident be unable to do so and any impact on family is also considered. This was evidenced by documentation and files viewed.
		Training for all staff occurs at orientation and in the annual study days for HCAs and at the RN training days.

Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The restraint/enabler policy details the process for assessment. Assessment covers: the need; alternatives; attempted risk; cultural needs; impact on the family; any relevant life events; any advance directives; expected outcomes; and when the restraint will end. Completed assessment templates were sighted evidencing assessment, including consultation with family.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Restraint and enablers are only used to maintain resident safety and only as a last resort. The restraint coordinator discusses alternatives with the resident, family/whānau and staff. Once approved and in use, the restraint is closely monitored and documented. Documentation includes the method approved, when it should be applied, frequency of checks and when it should end. It also details the date, time of application and removal, risk/safety checks, food/fluid intake, pressure area care, toileting, and social interaction during the process. A restraint register is maintained, updated monthly and reviewed by the restraint coordinator who shares the information with staff at the monthly quality and clinical meetings.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	All restraints are reviewed and evaluated as per Oceania policy and requirements of the standard. Use of restraints and enablers is evaluated two-monthly or more often according to identified risk. The evaluation includes a review of the process and documentation, including the resident's care plan and risk assessments, future options to eliminate use and the impact and outcomes achieved. Family/whānau are included in the evaluation process. Evaluations are discussed at the monthly quality and clinical meetings.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	A review of documentation and interview with the CM demonstrated the monitoring and quality review of the use of restraints. The internal audit schedule was reviewed and included review of restraint minimisation. The content of the internal audits included the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff monitor restraint related adverse events while restraint is in use. Any changes to policies, guidelines, education are implemented if indicated. Data reviewed, minutes and interviews with staff including HCAs and RNs confirmed that the use of restraint has reduced and is only used as a last resort.

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 1.3.12.1 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 guidelines.	PA Moderate	All residents' medication charts audited had been reviewed by the GP three-monthly. However, in five out of twenty medication charts reviewed resident medication allergies and sensitivities were not documented.	Information relating to residents' allergies and sensitives is inconsistently documented.	Ensure all information relating to residents' allergies and sensitives is clearly documented. 90 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop	PA Moderate	The Oceania 'Behaviour that Challenges' policy for residents living in the secure dementia wing requires that all residents living in the secure dementia wing will have a plan for individual, motivational and	Documentation of 24-hour challenging	Ensure the Oceania 'Behaviour

and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.		recreational therapy over the 24-hour period. This information is to be documented on the 'Behaviour that Challenges Activities' chart. All residents living in the secure dementia wing have a behaviour assessment on admission, however, of seven files reviewed of residents in the secure dementia wing, none contained a 'Behaviour that Challenges Activity' chart as required by Oceania 'Behaviour that Challenges' policy.	behaviour care plans was not completed for residents assessed as needing secure dementia level care.	that Challenges' policy is implemented. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	The maintenance staff member identified in April 2020 there was a need to document and record each piece of electrical equipment in the facility. This is to ensure that all equipment is checked within the required timeframes. At audit a number of essential bio-medical equipment items were noted to be out of date, such as nebuliser (expiry 2017), oxygen concentrator (expiry 2018), emergency equipment oxygen regulator (expiry 2017), sphygmomanometer, two hoist battery chargers (expiry 2018), two pulse oximeters, and two thermometers. The items were tested at audit and confirmed to be safe. However, there is no documented system or process to ensure that the annual testing of biomedical equipment is completed in a timely manner. Each resident room, except those in the dementia unit where it is deemed unsafe to do so, has a refrigerator. Residents use the refrigerators to store personal food items such as chocolate, salami and cheese. The household staff confirmed that refrigerator controls are checked to ensure the temperature is set at the designated temperature. However, there is no ongoing monitoring process in place to these refrigerators' temperatures are maintained within a safe range. Monitoring forms demonstrate that refrigerators in communal areas and those storing medications are monitored, however the thermometers used in these areas are not calibrated annually to ensure accuracy. There is a robust system and process to ensure all kitchen refrigeration temperature probes are calibrated as per the Food Control Plan requirements (refer 1.3.13).	i) There is no implemented system to ensure that all biomedical testing is completed in a timely manner. ii) The temperatures of refrigerators in residents' rooms are not monitored. iii) The system to validate the accuracy of thermometers, does not include those used in refrigerators in communal areas and those storing medications.	i) Ensure all biomedical testing is completed in a timely manner. ii) Ensure all resident individual refrigerator temperatures are monitored to ensure the temperatures are maintained within a safe range. iii) Ensure all temperature thermometers are validated for accuracy. 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.