

Oceania Care Company Limited - Gracelands Nursing Complex

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:	Gracelands Nursing Complex	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 5 February 2015	End date: 5 February 2015
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	81	

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Gracelands (Oceania) can provide care for up to 92 residents. This surveillance audit was undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and regional and executive management team. Service delivery is monitored. Staffing levels are reviewed for anticipated workloads and acuity with adequate staffing in place.

Three of three improvements required at the last certification audit around the quality improvement programme and care planning have been addressed.

Two improvements are required to performance appraisals and to restraint.

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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Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties and caring for the residents. Information regarding the complaints process was available to residents and their family and complaints were investigated. Staff communicated with residents and family members following any incident.

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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Gracelands has implemented the Oceania quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and business status reports allowed for the monitoring of service delivery. Benchmarking reports are produced that include clinical indicators, incidents/accidents, infections and complaints.

Staffing levels were adequate across the service and interviews with residents and relatives demonstrated that they had adequate access to staff to support residents when needed.

The improvements required at the certification audit around analysis of quality data and corrective action planning have been addressed.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nurses developed, reviewed, updated and evaluated residents person centred care plans at least six monthly. Residents or their family have had input into the development and review of care plans. Documentation evidenced that families were kept well informed. Residents and family interviewed were satisfied with the standard of care. There was an area identified that requires improvement relating to the evaluations of care during restraint use.

There are two activity programmes in place including one for rest home care and the other for hospital residents. The activity programmes support the interests, needs and strengths of residents. Residents and family interviewed confirmed they participated in the activities, and that the programmes have a wide variety of activities to choose from.

Appropriate medicine management systems were implemented with policies and procedures defining service providers' responsibilities. Staff responsible for medicine management had annual medication competencies completed. Medication files reviewed evidenced documentation of residents' allergies and sensitivities and three monthly medication reviews were completed by general practitioners. Weekly and six monthly checks of controlled drugs were completed. Medicine fridge temperatures were recorded and were within the recommended range.

Food, fluid and nutritional needs of residents were provided in line with recognised nutritional guidelines. Resident's individual needs were identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Oceania employs a dietitian who develops seasonal menus. Residents meetings included feedback on food services.

The improvements required at the certification audit around risk assessments and interventions to be recorded in the person centred care plans have been addressed.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness in place. There was a planned and reactive maintenance programme in place with issues addressed as these arise. Residents and family described the environment as appropriate with indoor and outdoor areas providing an environment that met their needs.

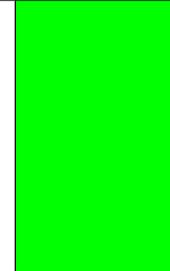
Restraint minimisation and safe practice

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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Documentation and implementation of restraint minimisation and safe practice policies and procedures demonstrated that residents were experiencing services that were least restrictive. The service had five residents using restraints and three residents using enablers and restraint usage was actively minimised.

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.

Surveillance was appropriate to the size and complexity of the organisation. Review of documentation provided evidenced the surveillance reporting processes were documented.

Results of surveillance were reported in the infection control register, identifying the different type of infections, treatment and outcomes. Surveillance data was recorded on the Oceania intranet and reported to their support office and staff members at meetings. Copies of clinical indicators reports were available on notice boards.

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	15	0	2	0	0	0
Criteria	0	41	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 organisation's complaints policy and procedures were in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and included periods for responding to a complaint. Complaint forms were available in the facility and family and residents interviewed knew where they could get a form.</p> <p>A complaints register was in place and the register included: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint was held in the complaints folder.</p> <p>Two complaints lodged in 2014 were selected for review. There was documented evidence of time frames being met for responding to these complaints with documentation indicating that the complainants were happy with the outcome.</p> <p>Residents and family members stated that they would feel comfortable complaining.</p> <p>There has been one complaint with the Health and Disability Commission (HDC) in August 2014 with the service waiting for this to be closed.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alerted staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurred. These procedures guided staff on the process to ensure full and frank open disclosure was available.</p> <p>Family were informed if the resident had an incident, accident, had a change in health or a change in needs as confirmed in 20 accident/incident forms and in the resident files.</p> <p>Family contact was recorded in residents' files.</p> <p>Interviews with family members confirmed they were kept informed. Family also confirmed that they were invited at least six monthly to the care planning meetings for their family member with this confirmed on the multidisciplinary form.</p> <p>Interpreter services were available when required from the district health board. There were no residents currently requiring interpreting services and all residents interviewed confirmed that staff were approachable and communicated well.</p> <p>The information pack was available in large print and staff advised that this could be read to residents.</p> <p>Staff have had training around communication in 2014 with a number of sessions offered during the year to accommodate staff.</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>Gracelands is part of the Oceania group with the executive management team including the chief executive officer, general manager, operations manager, regional operational managers and clinical and quality managers providing support to the service.</p> <p>Communication between the clinical and quality manager, the regional operations manager and the business and care manager took place on a regular basis (at least once a month) with more support provided as required.</p> <p>Oceania has a clear mission, values and goals and staff were able to describe these. They were displayed in the foyer of the service.</p> <p>The facility can provide care for up to 92 residents for hospital level of care (46 beds available) or rest home (46 beds available) level of care. During the audit there were 81 residents living at the facility including 47 residents at rest home level of care and 34 residents at hospital level of care.</p>

		<p>The business and care manager was responsible for the overall management of the facility, had been in the role for almost two years and had over ten years management experience. The business and care manager had a background in rescue helicopter work and in the corrections department.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Gracelands used the Oceania quality and risk management framework that is documented to guide practice. The business plan was documented and reported on through the business status reports.</p> <p>The service implemented organisational policies and procedures to support service delivery. All policies were subject to reviews as required with all policies current. Policies were linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies were readily available to staff. New and revised policies were signed by staff to say that they had read and understood them.</p> <p>All staff reported they were kept informed of quality improvements.</p> <p>There were monthly meetings that included the following: registered nurse; staff; quality and management meetings. Minutes were documented.</p> <p>The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures, and a health and safety plan were in place for the service. There is a hazard management programme documented with a hazard register for each part of the service. There was evidence that any hazards identified were signed off as addressed or risks minimised or isolated.</p> <p>There was an annual satisfaction survey for residents and family with a high level of satisfaction noted.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme noting that improvements identified as being required have a corrective action plan documented. Quality improvement data was analysed and used to improve service delivery. The two improvements required at the certification audit have been addressed.</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</p>	FA	<p>The business and care manager was aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There were no times since the last audit when authorities had to be notified.</p>

<p>family/whānau of choice in an open manner.</p>		<p>The service is committed to providing an environment in which all staff was able and encouraged to recognise and report errors or mistakes. Staff received education at orientation on the incident and accident reporting process. Staff understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Twenty incident reports selected for review had a corresponding note in the progress notes to inform staff of the incident. There was evidence of open disclosure for each recorded event. Information gathered was regularly shared through the monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. The results were displayed in the staff room and registered nurses and health care assistants described sighting these and reviewing trends.</p>
<p>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.</p>	<p>PA Low</p>	<p>All registered nurses hold current annual practising certificates. Current visiting practitioner's practising certificates included the general practitioner, dietitian, podiatrist and physiotherapist.</p> <p>Staff files randomly selected for audit included appointment documentation on file. An annual appraisal process was in place with most staff having a current performance appraisal.</p> <p>First aid certificates are held in the staff files along with other training records. Police checks were completed.</p> <p>All staff completed a comprehensive orientation programme. Health care assistants were paired with a senior health care assistant until they demonstrated competency on a number of tasks including personal cares. Annual medication competencies were completed for all registered nursing staff and health care assistants who administered medicines to residents. Other competencies were completed including: hoist; oxygen use; hand washing; wound management; moving and handling; restraint; nebuliser; blood sugar and insulin; assisting residents to shower.</p> <p>Mandatory training was identified on an Oceania wide training schedule. Training for staff at this site occurred as a day per year with training topics repeated during the year, so that all staff had an opportunity to participate. There were folders of attendance records and training with a spreadsheet maintained with all training included. The health care assistants stated that they valued the training. Education and training hours exceeded eight hours a year for all staff reviewed.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy. There was a registered nurse on duty at all times and health care assistants in the rest home and hospital to meet current needs of residents.</p> <p>Residents and families interviewed confirmed that staffing was adequate to meet the residents' needs.</p> <p>There were 97 staff including the business and care manager, a clinical manager, 11 registered nurses and 57 health care assistants who provided care and support to residents.</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>Medicine management processes were in line with the legislative requirements. Medicines were prescribed and signed by the GP. Each resident had an individual medicines profile and medicines administration record, individually packaged medicines and medicine signing sheets. The GP and RN completed medicine reconciliation on admission for residents. A controlled drug register was maintained in the hospital and evidenced weekly and six monthly checks. Bulk controlled drugs were stored securely.</p> <p>Medications requiring refrigeration were stored in dedicated fridges, and the fridges are kept in secure rooms. The temperatures were recorded on a daily basis and were within the recommended range for medicines.</p> <p>Medicine reviews were completed by the GP and recorded in the medicines administration sheets and reviewed three monthly. There was evidence of the staff signing off medicines after administration, observed during the medicines round in the hospital.</p> <p>Staff members responsible for medicines management received on-going education and training and had current medicine administration competencies.</p> <p>The medicines management policies are aligned with legislative requirements. Medication audits were completed at regular intervals. Staff interviews confirmed the service had not residents who self administered medicines.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food services are in line with legislative requirements. The menu was developed by a dietitian and last reviewed in September 2014.</p> <p>Resident's individual dietary needs were identified, documented and reviewed as part of the nutritional assessment on admission of the resident. The chef was informed when resident's dietary needs changed. Additional food and snacks were available for residents in the form of fruit, biscuits and sandwiches.</p> <p>Residents are offered fluids throughout the day. Residents' files sampled demonstrate regular monthly monitoring of individual resident's weight. Residents and relatives interviewed were satisfied with the food service. The fridge and freezer temperature were monitored weekly. Food temperatures were checked at each meal time to ensure the food was serviced at an acceptable temperature.</p> <p>The kitchen staff had completed food safety training.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The PCCPs reviewed were resident focused, integrated, and promoted continuity of service delivery. Initial plans of care were developed on admission while the PCCPs were developed within three weeks of admission. The facility used an integrated document system where the GP, allied services, the RNs, diversional therapist, physiotherapist and other visiting health providers wrote their care notes.</p> <p>Interventions sighted were consistent with the assessed needs and best practice. Goals were realistic, achievable and clearly documented. The service recorded intervention for the achievement of the goals. The improvement required at the certification audit has been addressed.</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>Residents received adequate and appropriate services meeting their assessed and desired needs. Resident files evidenced that care plans record interventions based on the assessed needs, desired outcomes or goals of the residents.</p> <p>The GP documentation and records were current. Visual inspection evidenced adequate continence and dressing supplies in accordance with requirements of their Service Agreement. Resident interviews confirmed their care and treatment met their needs.</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, and the setting of the service.</p>	<p>FA</p>	<p>The service has a diversional therapist, and an activities assistant who developed and implemented the activity programmes. Residents and staff confirmed the activity programmes include input from external agencies and support ordinary, unplanned and spontaneous activities including festive occasions and celebrations.</p> <p>Residents' meeting minutes evidenced residents' discussion in relation to the activities programme. Interviews with the diversional therapist confirmed the activity programmes meet the needs of the residents.</p> <p>Activities attendance records were maintained and sighted. Resident confirmed their past activities are considered and that the programmes are varied.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Residents' files reviewed provide evidence that evaluations of person centred care plans (PCCP) are within stated timeframes; however the restraint plans were not evaluated regularly. Evaluations were conducted by the RNs with input from the resident, family, care staff, and activity staff. Families confirmed being notified of changes in residents' condition.</p> <p>Resident's interviews confirmed their participation in PCCP evaluations. There was recorded evidence of additional input from professional, specialist or multidisciplinary sources, including physiotherapist, podiatrist and dietitian. Short term care plans were in place for short term changes in condition.</p> <p>Residents' files evidenced referral letters to specialists and other health professionals.</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>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 17 January 2016). There have been no building modifications since the last audit.</p> <p>There was a planned maintenance schedule implemented and the maintenance staff confirmed implementation of this.</p> <p>The lounge areas were designed so that space and seating arrangements provided for individual and group activities and all areas were suitable for residents with mobility aids.</p> <p>The following equipment was available: pressure relieving mattresses; shower</p>

		<p>chairs; hoists and sensor alarm mats. There was a test and tag programme and this was up to date. An external provider completed calibration of equipment annually.</p> <p>There are safe external areas for residents and family to meet/use and these included paths, seating and shade.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Residents with infections had short term plans completed. Clinical indicators were reported monthly to the quality/staff meetings, to the RN meetings, and care meetings (health care assistants) and via the Oceania intranet to the support office.</p> <p>Staff reported copies of meeting minutes and reports from the Oceania intranet were held in a folder in the staff room and this was confirmed during visual observations. Care staff interviews reported they were made aware of any infections of individual residents by way of feedback from the RN's, and daily handovers. Surveillance was completed monthly and the data entered into the intranet system as part of the organisation's quality data collection process.</p> <p>Infection control audits were completed as part of the internal audit programme. The facility participated in Oceania's internal benchmarking. Information was collated and expressed as graphs. Results of surveillance, conclusions and recommendations to assist in infection reduction were acted upon, evaluated and reported. A recent norovirus outbreak was contained within three days and managed according to the notification requirements of the public health department.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Documentation of restraint minimisation and safe practice policies and procedures, and the implementation of the policies, demonstrated residents are experiencing services that are least restrictive.</p> <p>There were three residents using enablers and five residents using restraints. The use of restraint is activity minimised, and sensor mats and high/low beds and bell mats used. Documentation reviewed for consent, assessment, monitoring and review. During review of restraint and enabler management safety it was found that two of the three restraint plans were not evaluated within the expected timeframes (Refer to criterion 1.3.8.2).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	Eight of ten staff files reviewed included a current annual performance appraisal. The business and care manager was catching up on the completion of some staff performance appraisals with a schedule in place for this to occur.	Two of ten staff files did not include a current performance appraisal.	<p>Ensure that all staff have an annual performance appraisal.</p> <p>180 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	Evaluations were documented for short term care plans and PCCP's. Evaluations were resident focussed, indicated the degree of achievement or response to the support and interventions as well as the progress towards meeting these goals. During review of restraint and enabler management safety it was found that two of the three restraint plans were not evaluated within the expected timeframes.	Restraints were not regularly evaluated.	<p>All evaluations are to be completed regularly, in a timely and appropriate manner.</p> <p>30 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.