# Coronation Lodge 2006 Limited

## 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 Health Audit (NZ) 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Coronation Lodge 2006 Limited

**Premises audited:** Coronation Lodge Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 17 March 2015 End date: 17 March 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:** 19

# 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** |
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|  | 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 |
|  | 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

Coronation Lodge Rest Home is operated by Coronation Lodge 2006 Limited and provides residential care for up to 20 residents who require rest home level care.

This unannounced surveillance audit was conducted against the relevant Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

Improvements are required from this audit relating to resident documentation following unwitnessed falls, aspects of medicine management and the dating of food when decanted.

## Consumer rights

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| 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. |

Staff demonstrated an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work and caring for residents. Information regarding resident rights, access to advocacy services and how to lodge a complaint was available to residents and their family and complaints were investigated. Staff communicated with residents and family members following any incident.

## Organisational management

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| 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. |

Coronation Lodge 2006 Limited is the governing body and is responsible for the services provided at Coronation Lodge Rest Home. A business plan was reviewed that included a vision statement, values, quality objectives, quality and risk management plan, and quality indicators.

Systems are in place for monitoring the services provided at Coronation Lodge Rest Home including weekly management meetings. The manager is an owner/operator/director of the company which has owned and operated Coronation Lodge since June 2006. The manager has aged care and management experience and is supported by an experienced registered nurse. The registered nurse is responsible for oversight of clinical care provided to residents.

Quality and risk management systems are in place. There is an internal audit programme, risks are identified and there was a hazard register. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms, and meeting minutes evidenced corrective action plans were being developed, implemented, monitored and signed off as being completed to address the issue/s that required improvement. Staff meetings were held monthly and there was reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified in these meetings. Graphs of clinical indicators were available for staff to view along with meeting minutes.

There are policies and procedures on human resources management. All health professionals have current practising certificates. The aged care education (ACE) 'Supporting the Older Person' education programme is provided. All staff have either completed or commenced the ACE education programme. In-service education is provided via compulsory education days that are provided twice a year and staff are rostered to attend these. Additional education is provided at least monthly. Staff records provided evidenced that human resources processes were followed and individual education records were maintained.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. Care staff reported there was adequate staff available and that they were able to get through their work. Residents and families reported there is enough staff on duty to provide care.

## Continuum of service delivery

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| 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. |

Initial assessment, care and support are provided by competent staff, with on-going evaluations completed by a registered nurse. Nursing interventions are consistent with best practice and care plans are well utilised.

There is a range of activities which are appropriate for the residents. Residents and families interviewed confirmed they were well supported to maintain interests and participation was voluntary.

The service has a documented medication management system and medication administration is completed by staff who are assessed as being competent to do so, however, there are improvements required to ensure all stages of medication management comply with safe practice guidelines and legislation.

Resident’s nutritional needs are met. Resident’s dietary needs are catered for and regular monitoring completed. There is a low risk area of improvement related to ensuring food stuffs are dated.

## Safe and appropriate environment

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| 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. |

A current building warrant of fitness was displayed. Any maintenance issues are addressed and proactive maintenance is carried out. Residents and family described the environment as meeting their needs.

## Restraint minimisation and safe practice

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| 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. |

There are documented guidelines for the use of restraint and enablers, and managing challenging behaviours. Staff received training and demonstrated an understanding of the appropriate and safe use of restraint and enablers to maintain independence

## Infection prevention and control

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| 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. |

Infection prevention and control policies and procedures are documented. There is a designated infection control co-ordinator who is responsible for ensuring monthly surveillance is completed and monitoring of infection control practices. Documentation sighted provided evidence that all staff are educated as part of on-going in-service education.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| **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 | 13 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 1 | 2 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The manager/owner is responsible for the management of complaints and there are appropriate systems in place to manage the complaints processes. The complaints register reviewed included nine internal complaints for 2014 and 2015.  There have been no investigations by the Ministry of Health, District Health Board, Health and Disability Commissioner, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit.  Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place that ensures residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and family interviewed demonstrated an understanding and awareness of these processes. Resident meetings were held monthly and residents are able to raise any issues during these meetings. Residents and family interviewed and review of resident meeting minutes confirmed this. Review of the collated resident and family survey for December 2014 evidenced residents and families knew the process for making a complaint.  The complaint process was observed to be readily accessible and displayed. Review of staff meeting minutes and the weekly manager/registered nurse (RN) meeting minutes evidenced reporting of complaints to staff. Care staff interviewed confirmed information was reported to them via their staff meetings. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Interpreter services are available to residents via interpreter services and offered to residents if needed. The manager/owner advised there are no residents who have required interpreter services.  Residents and family interviewed confirmed communication with staff was open and effective. Care staff were observed communicating effectively with residents during the audit. Monthly newsletters were also sent to families and copies given to residents. Residents’ files evidenced residents were consulted and informed of any untoward event or change in care provision and included in care reviews. Residents and families responded positively concerning effective communication from the resident and family survey collated in December 2014.  The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the education programme. Staff interviewed confirmed their understanding of open disclosure. Communication with family is documented in the residents’ communication records. Incident forms evidenced families were informed when incidents occurred. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Coronation Lodge 2006 Limited is the governing body and is responsible for the services provided at Coronation Lodge. A business plan for 2015 – 2016’ was reviewed and included a vision statement, core values, quality objectives, quality indicators, and scope of service. Values, mission statement and philosophy were displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.  Systems are in place for monitoring the services provided at Coronation Lodge including regular weekly management meetings involving the manager/owner and the RN. The manager is the owner/operator/director of the company which has owned and operated Coronation Lodge since June 2006. A current organisation chart clearly showing lines of responsibility and delegations of authority was reviewed.  The manager/owner has aged care and management experience and is supported by an experienced registered nurse who works 25 hours a week. Review of the manager's and RN's files indicated they have undertaken training in relevant areas. The registered nurse is responsible for oversight of clinical care provided to residents and has a current practising certificate.  The facility is certified to provide rest home level care. There are 20 beds provided and there were 19 residents on the day of this audit.  The facility has contracts with the DHB to provide aged related residential care -rest home, residential respite services - rehabilitation and support services, and long term support - chronic health conditions. |
| 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 | There is an internal audit programme in place and completed internal audits for 2014 and 2015 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identified health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risks. A health and safety manual includes relevant policies and procedures.  Clinical indicators and quality improvement data is recorded on various registers and forms and these were reviewed on site. There was documented evidence that quality improvement data was collected, collated, and analysed to identify trends and corrective actions were developed, implemented and evaluated. Clinical indicators and quality and risk issues were reported to staff. Meeting minutes and reports reviewed also evidenced discussion of any trends identified, as well as reporting on infection control and health and safety. Staff reported they are kept well informed of quality and risk management issues that included clinical indicators. Copies of meeting minutes and graphs of clinical indicators were available for staff to view.  Adverse events were documented on accident/incident forms and copies of these were retained in the residents’ files. (Link to 1.2.4 and 1.3.3.3)  Policies and procedures reviewed were relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly, including a policy for document update reviews and document control policy. Signing sheets demonstrated staff were updated on new/reviewed policies, and this was confirmed by care staff. Care staff confirmed the policies and procedures provide appropriate guidance for the service delivery and they were advised of new policies / revised policies.  Current first aid certificates were sighted for the manager/owner, RN, and a number of care staff. There is at least one staff member on duty with a current first aid certificate. |
| 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 | Staff document adverse, unplanned or untoward events on an incident/accident form which are then reviewed by the manager/owner and the RN and corrective action plans developed. Documentation is then filed in residents’ files and entries made in residents’ progress notes. Data reviewed for 2014 and 2015 included summaries of various clinical indicators. Staff are not consistently recording neurological observations on the incident/accident forms following unwitnessed falls (link to criterion 1.3.3.3).  Adverse events are discussed during the weekly management meetings and copies of completed accident/incident forms are sent to family members. Family members confirmed this.  Staff confirmed during interviews they were made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct, which was also confirmed through review of staff files and other documentation. Policy and procedures comply with essential notification reporting including health and safety, human resources and infection control. The manager/owner advised there had been one essential notification to the district health board (DHB) since the previous audit relating to a norovirus outbreak. |
| 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 | There are policies and procedures on human resource management and copies of current annual practising certificates were held for the RN, GPs and pharmacist. The skills and knowledge required for each position within the service was documented in job descriptions which outline accountability, responsibilities and authority which were reviewed along with employment agreements. Individual records of education were maintained for each staff member and copies reviewed. Staff files indicated reference and police vetting was undertaken.  The manager /owner is responsible for oversight of the in-service education programme. The education programmes for 2014 and 2015 were reviewed and evidenced education was provided at least once a month as well as via compulsory education days held twice a year. Staff were rostered to attend these study days. All care staff involved in medicine management have current medication competencies.  The aged care education (ACE) 'Supporting the Older Person' education programme is provided and an external educator is an ACE Assessor. All staff have either completed or commenced the ACE education programme.  An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff performance is reviewed at the end of the orientation and annually thereafter. Orientation for staff covers the essential components of the services provided. Staff confirmed they have completed an orientation. Care staff also confirmed their attendance at on-going in-service education and that their performance appraisals are current. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a clearly documented rationale for determining service provider levels and skill mix so that a safe services are provided at Coronation Lodge. This was confirmed by a review of the staffing rosters. There is an experienced RN employed and duty leaders on each shift. The manager/ owner and the RN are on call if required after hours.  Care staff interviewed reported that there was enough staff on duty and they were able to get through the work allocated to them. Residents and family interviewed reported there were enough staff on duty to provide care. Observations during this audit confirmed adequate staff cover was provided. |
| 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 | There are documented policies and procedures for all stages of medication management, however, not all stages of medication management were consistently completed to comply with safe practice guidelines. Administration records are maintained. Interviews with staff and a review of staff files confirmed that only staff who had been assessed as competent were responsible for medication management. The medication trolley, medication room and cupboard were observed to be locked, with the keys being held by the staff member responsible for medications on that day.  All medicines are prescribed by the GP using a pharmacy generated medication chart. Allergies and sensitivities are identified. Individually prescribed medications are used and a robotics system utilised. A controlled drug register is maintained with evidence of regular weekly reconciliation, and pharmacist involvement. One medication file sampled included a resident who self-administered eye drops. The resident had been assessed as competent to self-administer the eye drops and the relevant form confirming this was signed by both the resident and the RN. A medication fridge has daily temperature monitoring completed. Residents were prescribed medication that could be used when required and documentation included indications for use. |
| 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. | PA Low | Residents are provided with a well-balanced diet which meets nutritional requirements. Kitchen staff confirmed that there was dietitian input into the menu and the relevant documentation confirming this was sighted. A four weekly menu is followed. Residents and family interviewed were satisfied with the meals provided and a resident satisfaction survey sighted also confirmed this. Dietary assessments are completed on admission and special dietary requirements are highlighted and recorded on documents held in the kitchen. Individual food preference lists were sighted and any allergies identified. Kitchen staff had the required food safety qualifications. The kitchen was well stocked, clean and tidy. Fresh fruit and vegetables and other food stuffs were stored appropriately, however, decanted foodstuffs were not consistently dated. Food in the fridge was covered and dated. There was evidence of temperature monitoring and maintenance of a cleaning schedule. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The RN, care staff and family were interviewed regarding prescribed care, and care plans were sighted. Interventions were consistent with best practice. Short term care plans were developed as required, for example, for one resident who recently developed an infection.  Documentation completed daily by care staff confirmed care was being completed as prescribed and this was verified by documentation completed by the GP.  The handover process demonstrated that staff discussed the needs of individual residents on a daily basis. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities co-ordinator was interviewed. Activities are facilitated five days per week. Activities are planned in advance and include a variety of activities appropriate to residents’ needs.  Support is provided for residents to attend activities specific to their needs, and includes transport and one on one support as required. Residents were observed participating in the days planned activity. They were well supported and appeared to be enjoying the activity.  Participation records are maintained and residents confirmed participation was voluntary. An activities board was visible in a common area. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | A policy described the evaluation process. Files sampled included evaluations which were documented according to policy. They were conducted regularly and described the degree of achievement and progress towards meeting desired outcomes. The RN described the process, and evaluations sighted showed clear links to the care plan.  The RN initiated changes to the plan of care where progress was different from expected, for example, short term wound care plans.  Family members confirmed a high level of satisfaction with the service supporting the resident to achieve their desired outcome. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness was displayed at the entrance to the facility that expires 29 March 2015. The manager/owner confirmed processes were currently in place to obtain a new building warrant of fitness for when the current one expires. There have been no building alterations since the previous audit.  There is a maintenance schedule implemented. The lounge areas are designed so that space and seating arrangements provide for individual and group activities and are suitable for residents with mobility aids. The external areas are maintained, safe and appropriate to the resident group and setting.  Current calibration/performance verified stickers were observed to be on medical equipment. Current electrical safety tags were on electrical items. |
| 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 | The infection control co-ordinator confirmed a surveillance programme was maintained. Surveillance data was sighted and included infection details related to files sampled. Monthly analysis was completed and reported at monthly general staff meetings. There was an outbreak of norovirus in May 2014. Specialist infection control personnel from the DHB were accessed in a timely manner and the outbreak contained and resolved. There was evidence of staff being fully involved in a debriefing process and ongoing education and support provided.  The infection control surveillance is appropriate to the size of the service. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | A restraint policy was sighted and is appropriate for this service. Environmental restraint is practiced, with keypad access and a door alarm system which is activated at all times. Staff, visitors and residents are able to exit the facility by entering a specified code displayed above the keypad. Restraint is used appropriately. Only two residents currently require a form of restraint, which includes a resident who has a history of wandering. Care plans included use of alternative interventions to restraint, and the resident who wanders is able to freely mobilise within the facility. Staff have been provided with education related to managing restraint and challenging behaviour. |

# 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.

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| **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 | The lunch time medication round was observed. The staff member responsible, was observed administering medications, however, signing for administration was completed before medications had been given. Four of seven charts with discontinued medications had not been signed and dated, and start dates of prescriptions had not been consistently completed. All charts included resident photos; however, the photos did not include identification data to verify who the photo was of. Six of the ten medication charts reviewed had no documented evidence of three monthly GP reviews. | i)Staff signed for medication administration before medication taken.  ii) Discontinued medications were not consistently signed and dated.  iii) Start dates of prescriptions were not consistently completed.  iv) Photos were not identifiable.  v)Three monthly medication chart reviews were not consistently completed. | i)Staff to complete administration records after medications have been administered.  ii)Discontinued medications signed and dated.  iii)Start dates of prescriptions to be documented on all medication charts.  iv)Photos used as identification to include name, NHI, date of birth, date photo taken.  v)Medication charts to include evidence of three monthly GP review.  90 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Food storage areas were observed in the kitchen. Decanted food containers were not dated to show when containers had been filled. | Decanted food stuffs containers not dated. | Date all decanted food stuffs containers.  180 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | A resident experienced an unwitnessed fall. This was clearly documented in the incident report sighted. The report was incomplete and the necessary neurological observations had not been completed. | Neurological observations had not been completed following an unwitnessed fall. | Complete neurological observations following all unwitnessed falls.  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.

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End of the report.