

# Oceania Care Company Limited - Dunblane Lifestyle Care & Village

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## 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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Dunblane Lifestyle Care & Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 1 September 2015      End date: 1 September 2015
<b>Proposed changes to current services (if any):</b> None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> 64	

# Executive summary of the audit

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## 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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Dunblane (Oceania) can provide care for up to 75 residents requiring care at either rest home, hospital or dementia level. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the district health board contract.

The audit process included the review of policies and procedures, the review of 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.

Improvements required at the last certification audit around care planning and one aspect of medication have been addressed.

Improvements are required to documentation of resolution of issues when these are raised, plans around challenging behaviour for residents in the dementia unit and medicines chart review by the medical staff.

## 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.

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and care for the residents. Information regarding the complaints process is available to residents and their family and complaints reviewed are investigated. Staff communicate 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.

Dunblane 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 allow for the monitoring of service delivery. Benchmarking reports are produced that include clinical indicators, incidents/accidents, infections and complaints. An improvement is required to documentation of resolution of issues when these are identified.

Staffing levels reviewed are adequate across the service as per the staffing policy. Policies around recruitment and other aspects of human resources are implemented.

## 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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Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan has been utilised as a guide for all staff while the long term care plan is developed over the first three weeks. Care plans reviewed were individualised and risk assessments completed. Residents' response to treatment was evaluated and documented. Care plans reviewed were evaluated six monthly. Residents in the dementia unit do not all have 24 hour behaviour management plans and challenging behaviours are not recorded in the person centred care plans. Relatives were notified regarding changes in a resident's health condition.

Activities are appropriate to the age, needs and culture of the residents and support their interests and strengths. The residents and families interviewed expressed being satisfied with the activities provided by the diversional therapist.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. The general practitioner completed medical reviews of residents and medicines; however this was not consistently completed within the six-month timeframe. Medication competencies are completed annually for all staff that administer medications.

The facility utilises four weekly rotating summer and winter menus reviewed by a dietitian. The facility uses the services of a chef.

## **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.

There is a current building warrant of fitness. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family describe the environment as meeting resident needs. This also includes a secure dementia unit.

## **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.

The restraint minimisation programme defines the use of restraints and enablers. The restraint register is current. Policies and procedures comply with the standard for restraint minimisation and safe practice. Restraint assessment, documentation, monitoring, maintaining care, and reviews are recorded and implemented. Residents using restraints had no restraint-related injuries.

## 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 reviewed annually for its continuing effectiveness and appropriateness. Staff education in infection prevention and control was conducted according to their education and training programme and recorded in staff files.

Infections are investigated and appropriate antibiotics are prescribed according to sensitivity testing. The surveillance data is collected monthly for benchmarking. Appropriate interventions are in place to address the infections. There are adequate sanitary gels and hand washing facilities for staff, visitors and residents. Staff members were able to explain how to break the chain of infection.

## 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	13	0	3	0	0	0
Criteria	0	36	0	3	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

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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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The organisation's complaints policy and procedures are in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include timeframes for responding to a complaint. Complaint forms were observed to be available in the facility and family and residents interviewed know where they can get a form.</p> <p>The complaints register in place was reviewed and includes: 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 is held in the complaints' folder.</p> <p>Two complaints lodged in 2015 were selected for review. There was documented evidence of periods being met for responding to these complaints with documentation indicating that the complainants were happy with the outcome.</p> <p>Residents and family members interviewed state that they would feel comfortable complaining.</p> <p>There have not been any complaints with the Health and Disability Commission (HDC) or other authorities since the last audit.</p>

<p><b>Standard 1.1.9: Communication</b></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 alert staff to their responsibility to notify family/enduring power of attorney of any accident/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is available.</p> <p>Family are informed if the resident has an incident, accident, a change in health or a change in needs as confirmed in a review of six accident/incident forms and in the residents' files. Files reviewed demonstrated that family contact is recorded.</p> <p>Interviews with family members confirm they are kept informed. Family are invited at least six monthly to the care planning meetings for their family member and invited also to the two monthly resident/family meetings.</p> <p>Interpreter services are available when required, from the district health board. At the time of the audit, there were no residents requiring interpreting services. All residents interviewed confirm that staff are approachable and communicate well with them.</p> <p>An information pack is available in large print and staff interviewed advised that this can be read to residents.</p> <p>Staff training records evidence staff received training in 2015 around connecting with people and communicating.</p>
<p><b>Standard 1.2.1: Governance</b></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>Dunblane is part of the Oceania Care Company Limited with the executive management team including: the chief executive officer; general manager; operations manager and clinical and quality manager providing support to the service.</p> <p>Communication between the clinical and quality manager, the operations manager and the business and care manager takes place on a regular basis (four to six weekly) with more support provided as required.</p> <p>Oceania has a clear mission, values and goals and staff interviewed are able to describe these. These are displayed in the foyer of the service.</p> <p>The facility can provide care for up to 75 residents requiring: rest home level of care (20 beds); hospital level care (34 beds); dementia level of care (14 beds available) with seven swing beds that can accommodate rest home or hospital level of care. During the audit there were 64 residents living at the facility.</p> <p>The business and care manager, who has extensive experience in management, is responsible for the overall management of the facility and has been in the role since</p>

		October 2014. The business and care manager is supported by the clinical manager (registered nurse) who has four and a half years' experience as a clinical manager with one of those years at this facility. The clinical manager has a bachelor of nursing and a postgraduate certificate in gerontology.
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.	PA Low	<p>Dunblane uses the Oceania quality and risk management framework that is documented to guide practice. The business plan is documented and reporting occurs through the business status reports.</p> <p>The service has implemented organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies were noted to be readily available to staff in the staff room. New and revised policies are signed by staff to say that they have read and understand them.</p> <p>All staff interviewed reported they were kept informed of quality improvements.</p> <p>There are monthly meetings that include the following: staff; health and safety; infection control; quality activities and weekly management meetings also occur. Minutes of these meetings are documented.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service, which include a documented hazard management programme and a hazard register for each part of the service. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.</p> <p>There is an annual satisfaction survey for residents and family which on review showed that residents and family are satisfied with the service.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. Quality improvement data is analysed for opportunities to improve service delivery.</p> <p>Corrective action plans are documented, however not all showed evidence of resolution of issues. The business and care manager and clinical manager can describe how issues have been addressed.</p>
Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are	FA	The clinical manager and the business and care manager are aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents and infectious

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>disease outbreaks. There have been no times since the last audit when authorities have had to be notified apart from notification of the clinical manager and the business and care managers' appointment within the last year, which has occurred. The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff records reviewed demonstrate that staff receive education at orientation on the incident and accident reporting process. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared through the monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. Staff interviewed describe discussion at meetings around incident and accident data.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policy and processes are in place. All registered nurses hold current annual practising certificates. Current visiting practitioners' practising certificates reviewed are current and include health professionals visiting the service. Staff files include employment documentation such as job descriptions, contracts and appointment documentation. Police checks are completed and an annual appraisal process is in place with all applicable staff having a current performance appraisal documented in all files reviewed.</p> <p>A comprehensive orientation programme is in place and includes relevance to the dementia unit. All files reviewed show completion of orientation. Staff interviewed are able to articulate the buddy system in place for new staff members and the competencies required to be completed. Mandatory training and annual training is identified on an Oceania wide training schedule with attendance records maintained. The health care assistants state that they value the training. Education and training hours exceed eight hours a year for all staff reviewed.</p> <p>The training register and attendance sheets evidence completion of annual medication competencies. All of the staff working in the dementia unit have either completed level three training and the dementia units or, as in the case of a new staff member, are enrolled. There are at least 15 other staff who have also completed level three and dementia training.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p>	FA	<p>The staffing policy is the foundation for work force planning. Staffing levels were</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>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 reflect staffing levels that meet resident acuity and bed occupancy. There is at least one registered nurse on all shifts.</p> <p>Residents and families interviewed confirm that staffing is adequate to meet the residents' needs. Staffing in the dementia unit meets resident needs with staff able to describe management of any challenging behaviour.</p> <p>There are 70 staff at the time of the audit including the business and care manager, the clinical manager, activities staff including a diversional therapist, care and household staff.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>Medicine management policies and procedures are in place and implemented, include processes for safe and appropriate prescribing, dispensing and administration of medicines. The medication areas are free from heat, moisture and light, with medicines stored in original dispensed packs, in a secure manner. Medicine charts listed all medications the resident was taking, including name, dose, frequency and route to be given. Charts were signed by the GP. All entries were dated and allergies recorded. All charts had photo identification. Discontinued medicines were signed, however three monthly GP reviews were not all completed within the three monthly timeframe.</p> <p>All medicines are prescribed by the GPs using medication administration charts. Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored daily. Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. Sharps bins were sighted. Unwanted or expired medications are collected by the pharmacy. Medication administration was observed during lunch time in the hospital. The staff member checked the identification of the residents, completed cross checks of the medicines against the script, administered the medicines and then signed off after the resident took the medicines.</p> <p>Staff were authorised to administer medications. This required completion of medication competency testing, in theory and practice. All staff members responsible for medicines management complete annual competencies.</p> <p>Self-administration of medicine policies and procedures are in place. There were no residents who self-administered their own medication. Medicines management training occurs for staff.</p>

		The previous requirement for improvement relating to staff needing to use appropriate documentation/guidelines when crushing medicines and medication charts being block signed, ditto signed, and not dated or no year written down was fully implemented.
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	<p>The residents' individual food, fluids and nutritional needs are met. Residents are provided with a balanced diet which meets their cultural and nutritional requirements. The meals are prepared and cooked on-site. The menu review was based on nutritional guidelines for the older people in long-term residential care. A dietary assessment is completed on admission. This information is shared with kitchen staff to ensure all needs, food allergies, likes, dislikes and special diets are catered for. The facility provides modified diets (e.g. puree diets) to meet the dietary needs of the residents.</p> <p>The chef interview confirmed documentation of kitchen routines. Nutrition and safe food management policies define the requirements for all aspects of food safety. A kitchen cleaning schedule is in place and implemented. Labels and dates on all containers and records of food temperature monitoring are maintained. The chiller, fridge and freezer temperatures are monitored. The chef and the kitchen assistant have current food handling certificates.</p>
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>Residents receive adequate and appropriate services meeting their assessed needs and desired outcomes (refer to criterion 1.3.3). Interventions are documented for each goal in the long term care plans. Interview with the GP confirmed clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long term care plans such as: the speech language therapist; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist.</p> <p>Residents and family involvement in the development of goals and review of care plans is encouraged. Multidisciplinary meetings are conducted to discuss and review long term care plans. All resident files reviewed were signed by either the resident or by their family member. The previous requirement for improvement relating to PCCP's not adequately supporting goals and outcomes is implemented however there are requirements relating to challenging behaviour not having been included in the care plans and 24 hour behaviour management plans not having been completed for residents in the dementia unit (refer to criterion 1.3.3).</p>
Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan	FA	The activities programmes confirm that independence is encouraged and choices are offered to residents. The diversional therapist (DT) and two activities

<p>for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>coordinators (AC's) coordinate the activities programmes. The DT provides different activities addressing the abilities and needs of residents in the hospital, rest home, dementia care and day care. Residents under the age of 65 have additional activities to ensure their specific needs, especially social needs, are met. The service had three residents under the age of 65 at the time of the audit.</p> <p>Activities include physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. During the onsite visit, activities included residents going for an outing, music and one-on-one activities. Residents and family confirmed they were satisfied with the activities programme.</p> <p>On admission, the DT completes a recreation assessment for each resident. The recreation assessments include personal interests, family history, work history and hobbies to ensure resident's participation in the activities. The DT and AC's complete activity plans for each resident. Reviews of activity plans were completed every six months, as part of the multi-disciplinary review, or when the condition of the resident changed. All resident files reviewed during the onsite audit had current activity assessments in place.</p>
<p><b>Standard 1.3.8: Evaluation</b> Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' files reviewed showed long term care plans had six monthly reviews completed. Clinical reviews are documented in the multidisciplinary review (MDR) records, which include input from: the GP; RNs; health care assistants; AC's; DT and other members of the allied health team. Daily progress notes are completed by the health care assistants and RNs. Progress notes reflect daily response to interventions and treatments.</p> <p>Residents are assisted in working towards goals. Short term care plans are developed for acute problems for example: infections; wounds; falls and other short term conditions.</p>
<p><b>Standard 1.4.2: Facility Specifications</b> Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date December 2015). There have been no building modifications since the last audit.</p> <p>A planned maintenance schedule is implemented and the maintenance staff document implementation of this.</p> <p>The lounge areas are designed so that space and seating arrangements provided for individual and group activities and all areas are suitable for residents with mobility aids.</p>

		<p>The following equipment is available: pressure relieving mattresses, shower chairs, lifting belts, scales, hoists and sensor alarm mats. A test and tag programme is in place. Equipment is calibrated.</p> <p>There are safe external areas for residents and family to meet/use and these included paths, seating and shade.</p> <p>The dementia unit has appropriate furnishings with a secure unit and outdoor area.</p> <p>The facility is being significantly renovated with new carpet, paint and furnishings.</p>
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	<p>Documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organization. Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators on the intranet.</p> <p>Residents with infections have short term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported monthly at staff, quality, and infection control and health and safety meetings. Interviews confirmed information relating to infections is made available for clinical staff during hand over and at staff meetings.</p> <p>Monthly analysis was completed and reported at monthly general staff meetings. The infection control surveillance is appropriate to the size of the service. The responsibility for the surveillance programme is that of a registered nurse. Information gathered was clearly documented in the infection log and maintained by the control coordinator. The infection control coordinator (ICC) collects infection control data and collates the surveillance data for benchmarking. The infection control surveillance register included monthly infection logs and antibiotics use. The organisation has an internal benchmarking system.</p>
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	<p>Staff interviewed, observations, and review of documentation demonstrated that the use of restraint is actively minimised. Restraints used in the facility include lap belts and bedrails. There were two residents using restraints and five residents using enablers on audit day. The files reviewed for restraint and enabler use showed enabler use was voluntary and the least restrictive option for the residents.</p> <p>Residents who used restraints had risk management plans in place. The restraints were documented in their long term care plans. There were no restraint related injuries reported.</p> <p>The service has a documented system in place for restraint use, including a current</p>

		restraint register. Reasons for restraint use were considered and documented in the restraint assessments. The restraint coordinator is an RN.
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## 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 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	<p>There is a policy around documentation of corrective actions and management of issues raised. Staff interviewed including the business and care manager and the clinical manager understand the process of documenting corrective actions and resolution of issues.</p> <p>On review, there was some documentation of resolution of issues when identified in internal audits.</p> <p>Review of the data collected demonstrated analysis of data.</p>	Resolution of issues raised such as those raised through internal audits is not always documented.	Document evidence of resolution of issues.  180 days
Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing,	PA Low	Four of the 12 medicines charts reviewed did not evidence of the GP signing the records at three monthly intervals.	Not all medicines charts reviewed showed evidence of the GP signing the records as reviewed.	All medicines charts to be reviewed at three monthly intervals.

dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.				30 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 Low	All the resident files in the dementia unit were reviewed for a description of how their behaviour is managed over 24 hours. Nine out of 11 residents in the dementia unit did not have the description of how their behaviour is managed over 24 hours recorded in their records. Two of the files, of residents who present with challenging behaviour, were reviewed for evidence of the management of challenging behaviour in their PCCP's. Neither file demonstrated evidence of challenging behaviour having been included in the PCCP's.	i) The description of how behaviour is managed over 24 hours has not been implemented for all residents in the dementia unit and ii) challenging behaviour was not consistently recorded in the PCCP's of those who present with challenging behaviour.	i) The service to have 24 hour behaviour management plans for all residents in dementia care ii) Where residents present with challenging behaviour, the challenging behaviour should be included in the PCCP's.  30 days

## **Specific results for criterion where a continuous improvement has been recorded**

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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 audit.

No data to display

End of the report.