

Oceania Care Company Limited - Trevellyn Home & Hospital

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:

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

Dates of audit: Start date: 25 February 2016 End date: 26 February 2016

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: 97

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

Trevellyn Home and Hospital (Oceania Care Company Limited) can provide care for up to 105 residents requiring care at either rest home or hospital level with 97 residents on the day of audit. 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.

The previous requirements identified at certification audit around a forum to discuss incidents and accidents, handover, interventions in resident files, and most medication issues have been addressed.

Improvements required at certification to review care plans and review of the medicines charts by the general practitioner have not been met.

This surveillance audit identified improvements required to the following: the quality and risk management programme, performance appraisals and documentation of medication charts.

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 interviewed are able to demonstrate an understanding of residents' rights and obligations including the complaints process. Information regarding the complaints process is available to residents and their family and complaints reviewed are investigated with documentation completed and stored in the complaints folder. Communication with residents and family members is recorded in the resident's files. Residents and family state that the environment is conducive to communication including identification of any issues.

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 medium or high risk and/or unattained and of low risk.
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Trevellyn Home and Hospital has documentation of the Oceania Care Company Limited 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 include clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented.

Staffing levels are adequate across the service with human resource policies implemented. This includes evidence of recruitment and staffing. Rosters indicate that staff are replaced when on leave.

The improvement required to provision of a forum to discuss incidents and accidents has been met with clinical and staff meetings held monthly.

Improvements are required to documentation of discussion of clinical indicators, corrective action planning, documentation of resolution of issues, documentation of incident and accident forms and completion of performance appraisals.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Service provision is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into care planning and having choices. Sampling of residents' clinical files validated service delivery to the residents. There is a requirement for improvement relating to care plans to be reviewed six monthly or when needs or progress is different from expected. The service uses short term care plans for acute problems.

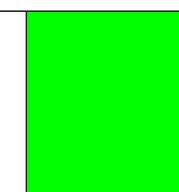
The residents and family interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Medication areas, including controlled drug storage, evidence a secure medicine dispensing system. Review of staff competencies confirmed all staff have current medication management competencies. The service has policy to guide self-administration of

medicines. No residents were self-administering their medicines on audit days. There is a requirement for improvement relating to three monthly medicines reviews to be completed for all residents.

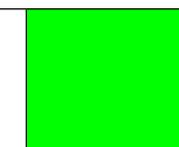
Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. The kitchen staff completed food safety training.

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. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family interviewed describe the environment as appropriate with indoor and outdoor areas that meet 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 of restraints and enablers includes identification of risks and monitoring time frames. Definition of restraint and enabler use is congruent with legislation. There is a job description for the restraint coordinator and the service is maintaining a restraint register.

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 prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. Staff are familiar with infection control measures and the use of personal protective equipment.

The infection control surveillance programme is appropriate for the size and complexity of the services provided. Surveillance is completed at monthly intervals and contributes to the quality improvement within the facility. The service had two outbreaks of infection since the last audit which were successfully managed.

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	11	0	1	4	0	0
Criteria	0	35	0	2	4	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>	FA	<p>The organisation's complaints policy and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes periods for responding to a complaint. Complaint forms are available in the facility.</p> <p>A complaints register is in place and the register 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 complaint folder. Two complaints were tracked and the review indicates that all timeframes taken to inform the family and resolve the issues raised were met.</p> <p>Residents and family members all state that they would feel comfortable complaining.</p> <p>There have not been any complaints forwarded by the Health and Disability Commission or other external authorities since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accidents/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is available.</p> <p>If the resident has an incident, accident, a change in health or a change in needs, then family are usually</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>informed as confirmed in a review of accident/incident forms and in the residents' files (refer 1.2.4.3).</p> <p>Files reviewed include documentation around family contact. Interviews with family members confirm they are kept informed. Family confirm that they are invited at least six monthly to the care planning meetings for their family member.</p> <p>Interpreting services are available when required from the district health board. The business and care manager states that families are involved in resident care and can interpret when required. There were residents requiring interpreting services at the time of the audit and staff and family interviewed confirm that family are able to interpret for the residents involved. Residents interviewed confirm that staff are approachable and communicate in a way that meets their needs. The business and care manager has an open door policy that allows residents, family and staff to communicate any issues at any time.</p> <p>An information pack is available in large print and staff interviewed advised that this could be read to residents. Staff training records include training around connecting with people and communication.</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>Trevellyn Home and Hospital is part of the Oceania Care Company Limited with the executive management team including the chief executive officer and general manager, regional operational manager and clinical and quality manager providing support to the service. Communication between the clinical and quality manager, the regional operations manager and the business and care manager takes place on a regular basis (at least once a month), with more support provided as required.</p> <p>Oceania Care Company Limited has a clear mission, values and goals and staff interviewed are able to describe these. These are displayed in the service.</p> <p>The facility can provide care for up to 105 residents requiring rest home or hospital level of care. Fifty-seven bedrooms are designated as being able to be used for residents requiring rest home level care only. During the audit, the occupancy was 97; (53 residents requiring rest home level care, including two residents requiring respite care and 44 requiring hospital level care). Three residents are identified as being less than 65 years of age, with one on a long term health conditions contract.</p> <p>The business and care manager has been with the service for 13 months having had experience as an auditor of health services and management experience at other services. The business and care manager is a registered nurse with a current annual practicing certificate and evidence of at least eight hours training in management related topics. The clinical manager provides clinical oversight of the service, however the business and care manager continues to provide clinical oversight to support the newly appointed clinical manager.</p>
<p>Standard 1.2.3: Quality</p>	<p>PA</p>	<p>Trevellyn Home and Hospital uses the Oceania Care Company Limited quality and risk management framework</p>

<p>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>	<p>Moderate</p>	<p>that is documented to guide practice. The business plan is documented and reporting occurs through the business status reports. This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products.</p> <p>The service implements 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 are readily available to staff and new and revised policies are signed by staff to say that they have read and understand them. The policy around pressure injuries has been reviewed and is in draft. This has been sent to Oceania business and care managers and managers to make final comment.</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 can be analysed through meetings and benchmarking. A meeting schedule is partially implemented with some aspects of the quality and risk management programme consistently discussed. Improvements are required to the following: consistency of meetings as per schedule; discussion around clinical indicators; corrective action planning and documentation of evidence of resolution of issues. The improvement required at the previous certification audit around a forum to discuss incidents and accident data has been addressed with clinical (registered nurse) and staff meetings held monthly, as per schedule. Incidents and accidents are recorded as being discussed in meeting minutes reviewed (refer 1.2.3.6 and 1.2.4.3).</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service, which includes a documented hazard management programme and a hazard register for each part of the service. Any hazards identified are signed off as addressed or risks are minimised or isolated.</p> <p>There is a satisfaction survey for residents and family with these completed in February and December 2015. The satisfaction surveys indicate that residents are satisfied with the service overall with some opportunities for improvement identified. A corrective plan for both surveys indicates that issues and suggestions raised by residents and family 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</p>	<p>PA Low</p>	<p>The business and care manager and the clinical 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 disease outbreaks. Times when authorities have had to be notified are documented and retained on the relevant file.</p> <p>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 understand the adverse event reporting process</p>

<p>consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>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. Information gathered is shared at monthly meetings with incidents graphed and benchmarking of data occurring with other Oceania facilities (refer 1.2.3.8). Documentation of information required in incident forms reviewed was not always completed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Human resource policy and processes are in place. All registered nurses hold current annual practising certificates. Current visiting practitioners' practising certificates reviewed are current and include the general practitioners, pharmacists, dietitian, podiatrist and physiotherapist. Staff files include employment documentation such as job descriptions, contracts and appointment documentation on file. Criminal vetting is completed.</p> <p>An annual appraisal process is in place with evidence of staff having an annual performance appraisal expected to be held on file. An improvement is required to completion of these.</p> <p>A comprehensive orientation programme is available for staff. Staff files show completion of orientation. Staff are able to articulate the buddy system in place and the competency sign off process completed. Three new staff interviewed state that they have had an orientation that included reading of policies and procedures, introduction to residents, staff and to the Oceania processes and buddying on all shifts.</p> <p>Mandatory training is identified on a training schedule. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training held. Staff receive annual training that includes attendance at training sessions and annual individualised training around core topics such as: medication; restraint; infection control; health and safety; manual handling and continence. Registered nurses have an hour of training at each meeting that includes relevant topics such as: pain management; complaints management; nutrition; assessments; medication administration and falls. Staff have completed training around pressure injuries.</p> <p>There are five registered nurses trained to complete interRAI assessments and two others enrolled.</p> <p>The training register and training attendance sheets show staff completion of annual medication and other competencies such as: hoist; oxygen use; hand washing; wound management; moving and handling; restraint; nebuliser; blood sugar and insulin. Education and training hours exceed eight hours a year for all staff reviewed. The health care assistants state that they value the training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</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 meet resident acuity and bed</p>

<p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>occupancy. Rosters indicate that residents requiring either hospital or rest home level of care are supported by an adequate number of staff on duty at any given time. There is a registered nurse on duty at all times.</p> <p>Residents and families interviewed confirm that staffing is adequate to meet the residents' needs with all stating that identified cares are provided.</p> <p>There were 90 staff at the time of the audit including the business and care manager and the clinical manager. There are 30 clinical full time staff including health care assistants and registered nurses with a physiotherapy assistant employed. There are household staff appointed that includes cleaners who provide seven day a week cleaning, laundry staff and kitchen staff.</p> <p>There is a roster review currently occurring. Staff work in pairs or groups of three and as a team to ensure that any resident is given appropriate care and support relative to their needs. There are always two staff, for example, when using a hoist - as described by staff interviewed and as observed on the day of audit.</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>PA Moderate</p>	<p>Medication areas, including controlled drug storage evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained. The service completes weekly checks and six monthly physical stock takes are completed by the pharmacy. The previous requirement for improvement relating to the controlled drugs register to be consistently signed by two staff members is implemented.</p> <p>The medication fridge temperatures are conducted and recorded.</p> <p>Current medication competencies for staff who administer medicines were sighted. The medication round was observed and evidenced the staff member was knowledgeable about the medicines administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures. The previous requirement relating to transcribing not to occur is implemented.</p> <p>Medication audits have been conducted and corrective actions are implemented following the audits. There were no residents self-administering medicines. The previous requirements for improvement relating to: allergies having to be documented; discontinued medicines to be signed and dated by the GP; medicines errors to be reported through the incident and accident reporting system and crushed medicines to be recorded to a level of detail ensuring the safety of residents, were implemented for all residents' files reviewed.</p> <p>The requirement for improvement relating to the GP not completing three monthly medicines reviews for all the residents remains open.</p>
<p>Standard 1.3.13: Nutrition, Safe Food,</p>	<p>FA</p>	<p>Interview with the cook confirmed kitchen staff have completed food safety training, and this was verified by food safety certificates. In interview, the chef confirmed they are aware of the residents' individual dietary needs. The</p>

<p>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>residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service and reported their individual preferences are met and adequate food and fluids are provided.</p> <p>On inspection, the kitchen environment was clean, well-lit and uncluttered. There was evidence of kitchen cleaning schedules, signed off as cleaning is completed. Fridge, chiller and freezer temperatures are monitored regularly and recorded, as are food temperatures.</p> <p>There is a seasonal menu, last reviewed by a dietitian in August 2015. Review of residents' files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as special diets, pureed meals along with alternative nutrition appropriate to the residents are available.</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>	FA	<p>The residents' PCCPs evidence the required interventions, desired outcomes or goals of the residents. The previous requirement for improvement relating to interventions not being documented well is implemented.</p> <p>Interviews with residents and their family confirm care and treatment meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the needs of the residents.</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>	FA	<p>The service employs an activities coordinator (AC) who is responsible for residents' activities. In interview with the AC, they confirmed the activities programme is available to all residents in the rest home and the hospital, sighted a copy of the programme. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations.</p> <p>There are activities assessments and activities care plans in residents' files reviewed. Activities care plans in the residents' files reviewed had intervention relating to the activities goals. The residents' activities attendance records are maintained as are activities progress notes.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	FA	<p>In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <p>The residents' progress is recorded at each shift. When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans were sighted in some of the residents' files, and these are</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>used when required. The family are notified of any changes in resident's condition, confirmed at family interviews. There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</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 December 2016). There have been no building modifications since the last audit.</p> <p>A planned maintenance schedule is implemented and documentation confirmed implementation of this.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids.</p> <p>Equipment relevant to care needs is available and staff confirm this is sufficient. 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 include 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>	<p>FA</p>	<p>Documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organisation. Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators on the Oceania intranet.</p> <p>Residents with infections have short-term care plans completed to ensure effective management and monitoring of infections. Interviews confirmed information relating to infections is made available for clinical staff during hand over and at staff meetings. The infection control coordinator (RN) is responsible for the surveillance programme. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interview, the ICC confirmed that there were two outbreaks since the last audit, however the service implemented processes and alerted the applicable services to manage the outbreaks appropriately.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	<p>FA</p>	<p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. Restraint and</p>

Services demonstrate that the use of restraint is actively minimised.		enabler use are documented in residents' care plans. There is a job description for the position of the restraint coordinator. The restraint register is maintained. The service had six restraints and seven enablers in use at the time of the on-site audit.
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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)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>There is an established meeting schedule and data is tabled at the meetings. Meetings are held consistently as per schedule for the heads of department, family, clinical registered nurse meetings, restraint and staff meetings. Resident and infection control meetings are not held consistently as per schedule. The infection control meeting record of attendance was documented for August 2015; resident meeting minutes were documented for June 2015 and February 2016.</p> <p>At times, the clinical indicator report is attached to meeting minutes. At times data is tabled in the meeting minutes. There is no consistent documentation in meeting minutes of discussion of clinical indicators.</p> <p>There is evidence in meeting minutes of discussion around some aspects of the data with some evidence of improvements made because of the discussions. The clinical manager and staff interviewed are able to describe</p>	<p>Resident and infection control meetings are not held consistently as per schedule.</p> <p>There is no consistent documentation in meeting minutes of discussion of clinical indicators with evidence that data that has led to service improvements.</p>	<p>Ensure that resident and infection control meetings are held consistently as per schedule.</p> <p>Document discussion of clinical indicators in meeting minutes with evidence of quality improvement as a result.</p>

		how data would lead to improvements.		90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>There is a process to record resolution of issues as these are identified. There is signing of resolution of issues in audits and in health and safety meetings when issues are identified. There is limited evidence of discussion of issues and resolution of issues in the meeting minutes when actions are identified.</p>	<p>The issues identified in the corrective action plan do not always match the issue identified in the audit report.</p> <p>Evidence of resolution of issues is not always completed in documentation of meeting minutes.</p>	<p>Ensure that corrective actions documented in the corrective action plan match the issue identified in the audit report.</p> <p>Ensure that evidence of resolution of issues is recorded as this occurs.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>There is a form to document any incident or accident. The form requires documentation of the resident when the incident relates to a resident and documentation of who has been contacted when required. This may include a family member, doctor and/or manager. At times, this information is documented.</p>	<p>Six of the thirty incident forms reviewed did not identify the resident involved. Nine of thirty incident forms reviewed did not document that relevant others (family member, doctor and/or manager) had been informed when this should have occurred.</p>	<p>Ensure that incident and accident forms are completed, with documentation of stakeholders involved and evidence of referral to others, as relevant.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing</p>	<p>PA Low</p>	<p>Staff are expected to have annual performance appraisals completed with a copy held on their file. Four of the ten staff files reviewed indicated that staff have completed annual performance appraisals. The business and care</p>	<p>Six of the ten staff files reviewed do not have a documented annual performance appraisal on the</p>	<p>Ensure that the plan to address the gaps around completion of</p>

education for service providers to provide safe and effective services to consumers.		manager is aware of the need to complete the performance appraisals and has a plan to implement this to address the gap.	file.	annual performance appraisals is completed and that staff then have an annual performance appraisal. 180 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	Medicines management information is recorded and communicated to residents and or their families. Two of fourteen medicines charts did not have three monthly reviews completed.	Two of fourteen resident medicines charts did not have three monthly reviews completed by the GP.	All residents to have three monthly medicines reviews completed by the GP. 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 Moderate	Person centred care plans (PCCPs) and short term care plans were in place for the management of resident's needs, however care plans were not reviewed in a timely manner.	Two of fourteen of the PCCPs and a short term care plan were not reviewed in a timely manner.	All care plans to be reviewed regularly. 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, 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.