# Dutch Village Trust

## 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:** Dutch Village Trust

**Premises audited:** Ons Dorp Care Centre

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

**Dates of audit:** Start date: 21 April 2016 End date: 21 April 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:** 39

# 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 |
|  | 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

Dutch Village Trust provides services at Ons Dorp Care Centre. The trust has a board of three directors. The day to day operation is overseen by a general manager. A clinical manager oversees all clinical matters. The care centre consists of 45 beds which provide either rest home or hospital level of care. The village operation and dwellings co-located with the care unit were not included in this audit.

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

Two areas identified for improvement in the previous audit have been addressed.

There were five areas identified for improvement during this audit related to the signing of advanced directives, care planning, assessment follow-up, evaluation of resident goals and staff medication competencies. The improvement related to medication competencies is rated as a high risk finding as only six of the 21 staff who administer medications have documented evidence that they are competent to perform this role. This has been reported to the Ministry of health as required.

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. |  | Some standards applicable to this service partially attained and of low risk. |

The service ensures that there are identified effective means of communication with all residents. This is confirmed during resident and family/whānau interviews. Interpreter services can be accessed as required.

One area identified for improvement in the previous audit related to the advance directive form has been addressed; however a new improvement was raised regarding staff acting upon a valid advance directive.

There is a complaints management system which is implemented. At the time of audit there are no outstanding complaints.

## Organisational management

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

The service has clearly documented values, scope, direction and goals. Business processes related to planning services to meet residents’ needs are identified. Residents and families/whānau interviewed expressed satisfaction with service.

The quality management system includes an internal audit process, complaints management and collection of data related to incident/accidents, restraint and infection control. Collected data is trended and used to identify opportunities for improvement where appropriate. Documentation identifies that quality and risk management activities and results are shared among staff, management, the board of trustees, residents and family/whānau as required.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met.

Human resources management processes are implemented to reflect current good practice.

## 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. |

Residents are admitted with the use of standardised risk assessment tools; however not all the required assessments are completed in a timely manner and care plans are not consistently developed and evaluated for all residents.

Planned activities are appropriate to the needs, age and culture of the residents. Residents reported that activities are enjoyable and meaningful to them.

The medicine management system does not consistently meet the required regulations and guidelines. Improvement is required regarding medication competencies of staff.

Food services meet the individual food, fluids and nutritional needs of the residents.

## 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. |

The facility has a current building warrant of fitness. There have been no changes to the building structure since the previous audit.

## 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 service has clear and comprehensive policies and procedures which meet the requirements of the restraint minimisation and safe practice standard. There are established systems and practices. Risk management plans are in place. Staff training and competency occurs. Monitoring and review of individual restraint interventions occurs at an appropriate frequency. The restraint register is current.

## 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. |

There is a documented infection control programme which is implemented and reviewed on at least an annual basis.

Surveillance for residents’ infections is occurring and is appropriate to the service setting. Episodes of infection are notified to the resident, family/whānau, general practitioner and staff in a timely manner and treatment provided. There has been one noro-virus outbreak since the previous audit.

## 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 | 1 | 3 | 1 | 0 |
| **Criteria** | 0 | 36 | 0 | 1 | 3 | 1 | 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](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).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | Advanced directives were an area identified for improvement in the previous audit. The concern regarding ambiguity of meaning has been corrected by the service introducing a new clearer form.  During the review of resident files, a new improvement arose related to staff acting upon valid resuscitation orders as an advanced directive. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Policy and procedures ensure an effective and fair complaints process is implemented as set out in policy. A review of complaints as shown in the complaints register identifies the timeliness of complaints management and that information is used as an opportunity to improve services.  There are no open complaints at the time of audit.  Family/whānau interviewed confirmed their knowledge and understanding of the complaints process. Both residents and family/whānau confirm that members of the management team are available to discuss any issues or concerns they may have. Residents interviewed were able to identify where they can obtain a complaints form from the foyer at the entrance to the building.  Staff stated they follow all policy requirements related to implementation of verbal and written complaints. Complaints are a standing agenda item for quality and risk meetings and care centre meetings with the trust board. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There are many residents with English as their second language. Most speak English and Dutch but effective communication has been maintained as many staff members are bilingual. Policies and procedures are in place related to the need to access interpreter services. The clinical manager confirmed that currently family/whānau and staff interpret for residents but that interpreter services would be used as required.  Family/whānau confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. The service demonstrates the principles of open disclosure. This is clearly documented in resident progress notes and on the accident/incident forms sighted. Information given to residents upon entry to the service and available at the front entrance to the facility describes residents’ rights to full and frank information. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation has a three-year business plan (2014-2016) which is reviewed regularly by the general manager (GM) and members of the trust board. Documented strategies cover all aspects of service delivery showing intended outcomes, performance indicators and targets along with a nominated person who manages and reports against each item to the monthly board meetings. The organisations vision, mission statement and philosophy are clearly documented.  The business is owned and operated by a board of trustees consisting of three members one of whom has clinical knowledge. The GM oversees the non-clinical aspects of the business. The GM has been in the role for over six years. He is supported by a clinical manager (CM) who is a registered nurse with over 10 years’ experience in aged care with five years in various management level roles. Education was evidenced for both members of management that is appropriate to the roles they undertake.  On the day of audit there were 31 hospital level residents and eight rest home level residents at the facility.  Interviews with residents and family/whānau confirmed their needs are met by the service. This is confirmed in the sighted resident satisfaction survey results (April 2016). |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has a quality and risk management system which is understood and implemented by service providers. The system includes the development and update of policies and procedures, internal audits, incident and accident reporting, health and safety reporting, restraint monitoring and reviews, infection control data collection and complaints management. Staff are able to verbalise examples of quality improvements that have been undertaken.  If an issue or deficit is found during a quality process, a corrective action is put in place to address the situation. Information is disseminated via area representatives who attend regular monthly quality and risk meetings. This was confirmed in meeting minutes sighted and verified by staff interviewed. Both managers are aware of any concerns that arise. Quality improvement data related to key components of service delivery are trended against previously collected data. Quality improvements that are put in place have measurable objectives and the outcomes are reported monthly to the board of trustees. This information is used to ensure services in place are meeting resident needs.  Actual and potential risks are identified and documented electronically. Staff can access this at any time. Newly found hazards are documented on specific hazard identification forms and communicated to staff, family/whānau and residents. Staff confirmed that they understood and implement documented hazard identification processes. Documentation shows that risks are eliminated, isolated or minimised. |
| 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 | Policy identifies that the organisation requires all incidents, accident and adverse events to be reported immediately. The service providers fully understood their obligations in relation to essential notification reporting and know which regulatory bodies must be notified. This is confirmed in the infection control outbreak (Norovirus December 2015) data sighted. A discussion with the CM who confirms awareness that reporting includes pressure injury requirements.  Staff interviewed stated they report and record all incidents and accidents and that this information was shared at staff handover and at staff meetings. Information shared includes any follow up actions required. (It was noted that follow-up related to neurological observations was not being conducted according to policy requirement. Refer to comment in criterion1.3.4.2).  Incident and accident forms sighted were well documented. They identify that family/whānau are notified. The CM stated that information gathered from incident and accident forms related to adverse events is used as an opportunity to improve services.  Family/whānau interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives. |
| 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 | The organisation carries out human resource management processes according to policy which reflects good employment practices and meets legislative requirements. A review of staff files show that job descriptions are in place for all roles undertaken at the service. Professional qualifications are validated for staff who require them.  New staff receive an orientation/induction programme that covers the essential components of service delivery. There is an ongoing education programme in place which covers all aspects of service delivery. The documentation related to education for 2016 data has yet to be fully computerised. Staff confirm education is offered both onsite and offsite on a regular basis. Certificates sighted in staff files confirm this. Staff stated the education offered assists them to meet the requirements of the role they are employed for and ensures they are able to meet residents’ needs.  Family/whānau interviewed stated the staff do a very good job and always present in a professional manner. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Documentation sighted in policy and on staffing rosters identified that suitably qualified staff are on duty to provide safe care and meet residents' needs. All shifts are covered by a registered nurse who holds a current first aid certificate.  The service provides dedicated kitchen, laundry and cleaning staff seven days a week. Activities staff work five days a week.  The review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed stated there are adequate staff on each shift and that they have time to complete all tasks to meet residents’ needs.  Residents and family/whānau interviewed stated they feel all their needs are met in a timely manner. |
| 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 High | The service uses an electronic system in administering medications to assist safe medicine administration. Prescribed medications are reviewed regularly. Medications that are only given “as required” have well-documented indications and instructions. Allergies are well-documented. The controlled drugs register is current. Weekly stocktakes are conducted by the RNs while the six-monthly controlled drugs register checks are conducted by the pharmacist. A system is in place in monitoring stock medications for the hospital. There are no expired or unwanted medications. A system is in place when returning expired or unwanted medications. All medications are stored appropriately. Medicine fridge temperature is monitored and evidences compliance.  Medicine reconciliation is conducted by the RNs when a resident is discharged back to the service.  Staff administering medications complied with the medication administration policies and procedures as evidenced in the observed medications rounds in both rest home and hospital units: however evidence of medication competencies was not consistently sighted in files sampled.  There are no residents who self-administer their medications; however there are self-administration policies and procedures in place.  The previous areas for improvements in relation to transcribing of prescribed medications and clear instructions for crushed medications have been fully addressed and 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 | Food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. A system is in place when receiving frozen deliveries. All meals are prepared and cooked onsite by a contractor. There was evidence of current food handling certificates.  Residents are provided with meals that meet their food, fluids and nutritional needs. The RNs complete the dietary requirement forms on admission and provide a copy to the kitchen. Additional or modified foods are also provided by the service.  Fridge and food temperatures are monitored and temperatures are within acceptable range for compliance. Cooked meals are plated from the main kitchen to the dining area and food for the residents in other units are transported via bain marie’s. The meals are well-presented and residents confirmed they are provided with alternative meals as per requested. All residents are weighed regularly.  Menus are reviewed annually by a dietitian. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | The registered nurses (RNs) use standardised risk assessment tools on admission. The assessment information is the basis for developing the resident’s initial plan of care and the long term care plan. New residents are admitted using the interRAI assessment tool which is completed within the required time frame. The identified areas of concern or potential areas that might decline generated by the interRAI assessments are used as the focus of the long term care plans.  Assessments are not consistently conducted when residents have witnessed or unwitnessed falls. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documented interventions in the long term care plans are sufficiently detailed to address the assessed needs and desired goals/outcomes. Interventions address the identified areas of concern or areas of potential decline as generated by the interRAI assessment tools. |
| 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 | Activities provided are appropriate to the needs, age and culture of the residents. The residents reported that activities are physically and mentally stimulating. The activities coordinator and the activities coordinator assistants developed the activity plans using the resident’s profile gathered during the interview with the resident and their families. The weekly activities are posted in the corridors in different areas within the facility and copies of activities are provided for all residents. Activity plans are well-documented and reflected the resident’s preferred activities and interests. A participation log was maintained. The activities coordinator and activities assistants refer the residents to the RNs when significant changes are noted regarding involvement in the activities that may require further investigation. Interviewed residents and families said that the activities provided by the service are adequate and enjoyable |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Care plans are developed and evaluated by the registered nurses. Changes to the care plans are evident in resident’s files when the desired outcomes are not met. Interviewed residents and families confirmed that they are involved in evaluating the care plans.  Care plans are not evaluated within the required timeframes. Short term care plans do not consistently evidence a resident’s response to treatment. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility has a current building warrant of fitness which expires on 23 November 2016. Documentation sighted confirms all checks are undertaken to maintain this. There have been no changes to the building footprint since the previous audit. |
| 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 | Surveillance for residents with infections is occurring and is appropriate to the service setting. Staff interviewed confirmed they report any suspected infections to a RN. Where applicable the GP is informed.  Suspected infections are reported on a specific form and review and follow up is undertaken as part of the infection prevention and control activities. The number and type of infections are analysed on a monthly basis. The results are communicated to management, staff and to the board of trustees on a monthly basis. The infection control coordinator has a job description and has undertaken appropriate training for the role. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The use of restraint is actively minimised. De-escalation techniques and lowering beds are utilised prior commencing the use of any restraint. There are four residents using restraints. There is one resident using an enabler. The restraint register is current and updated. The policies and procedures have good definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers. The restraint coordinator reviewed the current restraints in use and risk management plans are in place to reduce restraint-related incidents. |

# 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 1.1.10.7  Advance directives that are made available to service providers are acted on where valid. | PA Low | In response to the previous audit result the service is now using a new form which clearly covers all legislative requirements for advanced directive. Staff knowledge regarding what makes an advance directive related to resuscitation valid was limited. | Two of nine files reviewed had resuscitation instructions in place that were not signed by the resident but by the next of kin. When staff were interviewed they stated they were unaware of what made the forms valid. They did not know that a resident who is mentally competent must make their own decisions regarding their resuscitation status. Education covering documentation which included informed consent was presented on 19 April 2016 by the gerontology nurse specialist from the Waitemata District Health Board and the attendance sheet shows that the RNs interviewed attended this. Staff thought that the nominated next of kin could validate a resuscitation order by signing it. | Ensure all staff are aware of what makes a resuscitation order valid.  180 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA High | The RNs who administered the medications in the observed medication rounds in the rest home and hospital units complied with the medicine administration policies and procedures. | Six out of 21 staff administering medications have documented medication competencies. | Ensure that all staff who administer medications have current medication competencies.  7 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 | Not all stages of service provision is provided within the time frames that safely meets the assessed needs of the residents. New residents are admitted using the interRAI assessment tools. RNs developed both long term and short term care plans. One resident was admitted in 16.09.2015. However that the resident has a current interRAI assessment and the RN developed a long term care plan on the day of audit. An initial care plan was developed on admission. Care plans are evaluated by the RNs. | Two of nine files did not have short term care plans consistently developed.  One of nine files did not have a long term care plan developed. | Develop short term care plans when residents have episodes of acute infections.  Develop long term care plans in a timely manner in order to meet legislative and contractual requirements.  90 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | New residents are admitted using the interRAI assessment tool within the required time frame. The outcome trends generated by this assessment served as the basis of the resident’s long term care plan. Other standard assessment tools are used before using the interRAI assessment tool. Policies and procedures are in place when residents had a fall i.e. neurological observation. Ten out of 12 reviewed incidents of falls for the month of March 2016 showed that neurological observations are not completed post falls. | Assessments for neurological observations are not being undertaken to meet policy requirements. | Ensure policy requirements are met in relation to fall assessment procedures.  60 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Four out of nine reviewed long term care plans are not evaluated to show the progress made towards meeting desired goals/outcomes.  Two out of nine reviewed short term care plans do not evidence resident’s response to the treatment. | Long and short term care plans are developed by the RNs. Care plans are updated when the planned interventions are not effective to address the desired outcomes. Care plans are not consistently evaluated to show the resident’s progress towards meeting the desired goals. Short term care plans do not consistently evidence resident’s response to the treatment. | Review long term care plans within the required timeframes.  Provide evidence that short term care plans are evaluated to show resident’s response to the treatment.  90 days |

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

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

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

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

|  |
| --- |
| No data to display |

End of the report.