

Taslin NZ Limited

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group 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:	Taslin NZ Limited
Premises audited:	Otatara Heights Residential Care & Rehabilitation Home
Services audited:	Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 4 April 2016 End date: 4 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:	35

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
	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

Otatara Heights Residential is a residential and rehabilitation care facility located in Napier. The service provides rest home and rehabilitation care for up to 35 residents (26 rest home & 9 rehabilitation)

This unannounced surveillance audit was conducted against the relevant Health and Disability Services Standards and the service's contract with the district health board. The intent is to provide assurance the provider is continuing to meet all relevant standards.

There are three areas identified which require improvements identified at this audit. These are in the area of human resources, food services and evaluation of care plans in residents' files. The one around evaluation remains open from the last certification audit.

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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There was evidence that staff communicate effectively with residents and provide an environment conducive to good communication. There are processes in place to access interpreting services when this is required.

The service has complaints management system which meets requirements. There is a complaints register that contains any complaints received and actions taken to address any shortfalls.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Organisational structures and processes are monitored regularly by the management and board of directors. The manager/owner is suitably qualified and experienced to run the service with the support of the care manager. They are both supported by the clinical and non-clinical members of staff at the residential care facility.

Otatara Heights has a documented and implemented quality and risk management system that supports the provision of clinical care and support. Policies and procedures are developed and reviewed by the management team at least bi-annually. Quality and risk performance is reported through staff meetings, as well as being monitored by the board. Review of service delivery includes incidents/accidents, infections, complaints and reports from the internal audit programme.

The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Systems for human resources management are established. There are adequate staff numbers each shift to meet the residents' needs at both levels of care. The education programme for all staff is available and planned for the year. Staff education is encouraged.

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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Services are provided by suitably qualified and skilled staff to meet the needs of the residents. The interRAI assessment process is in progress and all residents have had an interRAI assessment. Timeframes for the development and review of long term care plans are met. A short term plan is developed when there are changes in the resident's needs that are not addressed in the long term care plan.

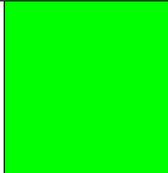
The general practitioner reviews all residents medically within the required timeframes and more frequently as needed. Pressure injury management and responsibilities are documented in policy and implemented. The care manager is fully informed in relation to reporting requirements for any pressure injuries.

A safe medication system was observed during the audit. The staff responsible for medication management have completed comprehensive competencies to perform this role.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

The menu is meeting nutritional guidelines, with any special dietary requirements being appropriately catered for. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

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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The building has a current warrant of fitness which expires on 1 November 2016. A previous area for improvement identified at the certification audit has been completed.

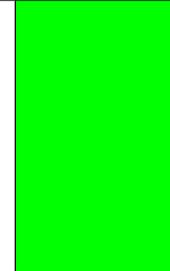
Restraint minimisation and safe practice

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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The facility is restraint free. Enablers are used if requested by residents to support independence and maintaining safety. All required policies and procedures are in place should they be needed at any time.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. The results of surveillance are reported through all levels of the organisation, and an external benchmarking programme is being participated in.

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	2	1	0	0
Criteria	0	36	0	3	1	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 complaints register, internal audits and sample of complaints for 2015 evidence that complaints are managed within time frames of Right 10 of the Code. Complaints forms are available at the reception area, with information given on the complaints process as part of the admission procedure and advocacy session with residents and families. Residents and family/whanau reported they are encouraged to provide feedback or make a complaint. There is one ongoing complaint which is being managed correctly and the Advocacy Service is involved.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The residents and family/whanau confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. A family/whānau communication sheet is held in each resident's file. Evidence of open disclosure is documented in the family communication sheets, on the accident/incident form and in the residents' progress notes. The families reported that communication from the service regarding any changes with their relative is a strength of the organisation.</p> <p>There is documented information on interpreter services in the cultural policies. Staff are aware of how to access an interpreter through the DHB or hospice services.</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>The facility is owner operated who has previous experience in other care facilities. There are rest home residents and residents under 65 who receive rehabilitation services. The services are planned to meet the individual needs of the residents. The facility owner /manager is being mentored by a master's student who is undertaking a masters in management and is an Age Concern supervisor. The owner/manager reported that she is enjoying the support and learning.</p> <p>The 2015-2017 business plan clearly documents the organisation's mission, philosophy, goals and objectives of the service. This is reviewed formally on an annual basis by the management team. There are monthly directors' meetings in which the care manager provides a report on the clinical aspects of meeting the organisation's goals.</p> <p>The care manager is suitably qualified but is not a registered nurse (RN). She has the support of four RN's who oversee the clinical care. The care manager has responsibility for the day-to-day care of residents.</p> <p>The residents and family/whanau reported a high level of satisfaction with the care and services provided at Otatara Heights. The residents and family/whanau satisfaction surveys confirmed positive feedback regarding the quality of support, care and activities provided.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The quality assurance and risk management programme details the quality policy and how the service is going to achieve its goals. The quality objectives are reviewed annually by the management team. The quality and risk systems are monitored through internal audits, surveys and management meetings. Each of the quality goals identified covers all aspects of care and service delivery. Staff are actively involved in the quality programme and demonstrated an understanding of what the organisation aims to achieve. A sample of internal audits identified that outcomes of the internal auditing and quality management systems are discussed at the monthly staff meetings and fortnightly managers' meetings. The outcomes are also reported to the board/directors. Staff confirmed they understood and implement the quality and risk management systems. The policies include interRai requirements.</p> <p>Quality data collection and analysis are maintained by the service and evaluation of results shared with staff, management team and the board/directors. Corrective actions/quality improvements are put in place where indicated. The internal audit corrective action/quality improvement forms sighted record the outcomes, actions needed, who is to implement the actions and the review of when the actions have</p>

		<p>been implemented. Data is collected and reviewed and evaluated for all key components of the service.</p> <p>The risk, hazard and emergency response plan identifies potential and actual hazards. The plan includes what the hazard is, potential harm, preventative actions and ways to eliminate, isolate or minimise the risk. The actions implemented are followed up to ensure the actions are achieving the desired results. A hazard identification form and the maintenance job request logs are used to record any new hazards. When new issues are identified, these are reviewed at the quality meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The owner/manager and care manager understand their responsibilities for essential notifications, including the essential notification of stage three and above pressure injuries.</p> <p>The incident/accident forms are used to report any adverse events. Staff demonstrated knowledge of their responsibilities of what to report through the incident/accident management system. There is a monthly collation of the adverse events, with actions implemented to address any shortfalls identified. If there are any ongoing hazards, these are then put on to the hazard register, with the actions to minimise the hazards regularly monitored.</p> <p>They have applied to be assessed for tertiary ACC and will be audited in two months.</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>	PA Low	<p>All staff and contractors who require an annual practising certificate (APC) have these validated at employment and annually. A register is maintained of when APC and competency assessments are due. Copies of APCs were sighted for all staff who require them.</p> <p>Staff files provided evidence that appropriate processes are implemented for the recruitment, employment and orientation of new staff. There are at least annual performance reviews for the staff. Where training or shortfalls in staff performance or achievement of goals/outcomes are identified, there are additional mentoring, support and coaching sessions implemented to assist staff throughout the year. There is an area for improvement relating to no evidence of staff appraisals being completed annually.</p> <p>The service provides training and education that is appropriate to the needs of the service and maintain records of the training provided. Training needs are identified in the annual performance appraisal process. Mandatory training to meet</p>

		<p>contractual obligations is two yearly, or more frequently for such topics as infection control and restraint minimisation and safe practice. The care staff, activities, kitchen and housekeeping staff are supported to gain appropriate national qualifications if they do not already have them. The education schedule was reviewed for 2015 and the upcoming 2016 year has content and variety and meets all obligations of the provider's residential care contract with the district health board. There are two RNs who are trained in interRai and all initial assessments are completed and are reviewed as part of the six monthly review.</p> <p>There is area for improvement relating to no evidence of annual appraisals being completed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing levels are based on contractual requirements, safe staffing indicators and the assessed needs of the residents. The care manager reported that the allocation and skill mix of the staff is reviewed to ensure the needs of the residents are met. The three RNs coordinate weekly to ensure there are appropriate staff numbers and skill mix to meet residents' needs and undertake a share of the on call duties. If there are residents who require more complex care or observing, additional staff are rostered. A review of rosters identified that the service is staffed to ensure there is a skill mix and sufficient numbers of staff to meet residents' needs. All sick leave and annual leave is shown and replacement staff noted. There is at least one staff member on duty each shift with a current first aid qualification. There are sufficient numbers of laundry, housekeeping, activities, support and administration staff. If unable to provide staff employed by Otatara Heights a bureau staff member will be employed.</p> <p>The residents reported there are adequate numbers of staff to meet their needs.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication protocols, procedures and guidelines 'Safe Management of Medicines' have been reviewed and updated. The service uses the blister system which is delivered monthly and checked on arrival.</p> <p>The lunchtime medication round was observed and a safe process was used. There have been no significant medication errors and the registered nurses can notify the GP with any queries or points of clarification as needed.</p> <p>The medication records randomly selected had been reviewed by the GP and any allergies/sensitivities are entered to alert staff. A system is in place for returning any unused or outdated medication to the contracted pharmacy. These are recorded and monitored.</p>

		<p>The medication room is in close proximity to the nurses' station and a medication trolley is available and is locked when not in use. Controlled drugs are managed correctly and meet legislative requirements.</p> <p>There were no residents self-medicating on the day of the audit. A self-medication policy is in place should this be required. The facility does not use standing orders.</p> <p>The medication fridge is monitored on a daily basis and the temperatures recorded which meet requirements.</p> <p>All staff who undertake medication administration have up to date competencies.</p> <p>Staff, GP and residents reported confidence and knowledge of the medications prescribed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>The food, fluid and nutritional requirements of the residents are provided in line with recognised nutritional guidelines. A six week menu is currently in place. A new four week menu has been developed and this is in the process of being reviewed and approved by a registered dietician.</p> <p>The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan.</p> <p>The kitchen was observed to meet a high standard of cleanliness. A cleaning schedule was sighted however this has not always been completed consistently as the cleaning is completed.</p> <p>Evidence of resident satisfaction with meals was verified by resident interviews and a survey undertaken recently resulted in changes being made in response to some suggestions.</p> <p>There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining room is clean, warm and light.</p> <p>Some aspects of food procurement, production, preparation, storage, transportation, delivery and disposal do not comply with current legislation and guidelines. There are some issues with the dating of all food as it is delivered and more consistent recording of daily temperatures for fridges, freezers and daily food serving is needed.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Support and care is individualised and focused on achieving desired outcomes/goals set. The registered nurses and care staff interviewed demonstrated appropriate skills and knowledge of the individual needs of all residents. The records reviewed showed evidence of consultation and involvement of the resident and family. The residents interviewed reported satisfaction with the care and services provided. One family member interviewed spoke highly of the care provided and the interaction of staff with individual residents and the homeliness of the environment.</p> <p>Short term care plans are developed and implemented as necessary for any event that is not part of the long term care plan, such as unexplained weight loss or wound care management. The registered nurses ensure the GP is kept well informed of progress.</p> <p>There are adequate stocks of wound and continence products to meet the needs of the residents. The care plans reviewed demonstrated interventions that are consistent with the residents' needs being able to be met. Observations on the day of the audit indicated residents are receiving care that is consistent with meeting their assessed needs. The registered nurse who was interviewed reported that all care plan interventions are accurate and up to date. The registered nurses are responsible for a number of residents from admission and in the longer term.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A significant and varied activity programme is in place at Otatara Heights. On admission, each resident and their family if appropriate had discussions around their activity preferences. This information was used to develop an individualised activity plan for each resident. Individual records are maintained of all activities residents participate in.</p> <p>A calendar of planned activities was developed (sighted) and this demonstrated a wide range of activities that reflect the diverse nature of the residents. The activities on site included current events, board games, church services, crafts, music, entertainers, a book club, a daily exercise programme, Tai Chi, Zumba and outdoor activities. Residents are also taken on regular outings into the community to age appropriate activities including riding for the disabled, swimming, movies, attendance at the Mosaic club, kite days, boccia and other community based events. A number of residents were participating in education and training activity in the community. All residents go on outside outings at least once a week, often more. There are twice weekly shopping trips to the local supermarket where residents purchase personal items which are stored in the residents' fridge/ freezer</p>

		<p>as required.</p> <p>An activity coordinator is employed at Otatara Heights Tuesday to Saturday from 9am to 4.30pm and Monday 9am to 3pm. Additional staff are allocated daily to provide transport and other resident support to activities as required. Residents interviewed all expressed satisfaction with the number and type of activities they were able to participate in and confirmed the appropriateness for them according to their age and interest.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Resident's files reviewed all showed evidence that evaluations are now being undertaken regularly. However these are only reflecting evaluation of clinical progress and outcomes. Where clinical goals and progress have been evaluated, appropriate changes have been initiated. No evaluation of social, cultural and recreational goals is occurring. Staff confirmed these evaluations are not covering all areas as required by the standard. Reviews are however occurring regularly for the clinical components.</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>	FA	<p>The current BWOF expires on 1 November 2016. There have been no changes to the buildings since the certification audit. A previous concern that was identified at the certification audit around remedial work for some of the bathrooms being required, has now been completed. A review of the placement of the grab rails has also been done and repositioning of some of these is in progress. The physical environment now supports residents to be as independent as possible and is appropriate to support their needs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. The type of surveillance undertaken is appropriate for the size and complexity of the facility. This includes monitoring of infections in the areas of gastrointestinal, skin, wounds, urinary tract, ear, nose, eye, mouth and upper respiratory tract. All data is collated each month and analysed to identify any significant trends or possible causative factors. All incidents of infections are presented at the monthly RN and quality committee meetings for review. Any ongoing actions required are identified and any necessary corrective actions discussed and implemented. Any immediate action for individual residents that is required, is presented to staff at hand over. Incidents of infections are graphed and shared with staff both on both a monthly and annual basis. A comparison of previous infection rates is used to analyse the effectiveness of the programme over the last three years was sighted. The infection control officer confirmed the facility is also taking part in a benchmarking programme along with 50 other</p>

		facilities. A number of initiatives including milkshake and ice block rounds have been initiated to ensure residents' fluid intakes are kept optimal.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Appropriate policies and procedures with clear definitions are developed for the facility which is restraint free. Restraint would only ever be used as a last resort option and appropriate systems are in place should this occur. A number of enablers are in use to assist with residents' personal safety. These are all voluntary, with an up to date register kept with all consents and relevant monitoring appropriately recorded. Staff have regular training every six months and as necessary for all new staff. The restraint coordinator reported in interview that enabler use is monitored as per the facility policies and procedures.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	During review of staff files evidence was not found of annual appraisals.	Staff files reviewed did not contain evidence of annual appraisals.	<p>Undertake staff annual appraisals and provide evidence in staff files.</p> <p>180 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Moderate	<p>There was no evidence of consistent dating of food being completed for both dried food and that which is stored in the fridges and freezers to ensure safe storage times are observed.</p> <p>Temperatures recordings were not completed consistently for all fridges and freezers. The cleaning schedules were sighted; however these were not being signed as completed by staff consistently as required.</p>	The dating of all food, recordings of daily temperatures in cold storage areas and the completion of cleaning schedules is not completed consistently.	<p>Implement dating of all food kept in the kitchen to ensure storage times can be monitored and managed appropriately. Temperature readings and recordings are to be completed regularly to maintain safe levels of storage at all times to comply with current legislation and guidelines. All cleaning schedules are to be signed off once cleaning has been completed.</p> <p>90 days</p>

<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>It was identified at the last audit that regular evaluations of care plans were not occurring. All files reviewed during this audit demonstrated that evaluations are now being completed now being regularly six monthly, or earlier if required, and documented but these are not comprehensive. There is no evaluation or documentation occurring to reflect progress and achievement against the resident focused identified goals and outcomes in the social, cultural and recreational areas of the care plans.</p>	<p>Evaluations are not being completed to cover all identified areas of service delivery.</p>	<p>Ensure all evaluations of residents 'care plans include all areas of identified goals and outcomes.</p> <p>180 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Low</p>	<p>In all files reviewed, where changes have been identified as being appropriate in the clinical delivery of services, these have all been implemented. With evaluations not being comprehensively completed in all areas, appropriate responses or changes to a resident's service delivery plan is not always occurring. Staff reported that relevant changes in the clinical areas are being implemented as appropriate, but again this is only reflecting progress in the clinical area.</p>	<p>Progress in all areas is not being evaluated regularly; therefore appropriate changes to service delivery are not being initiated in all areas as relevant.</p>	<p>Where progress is identified as being different from what is expected in social, cultural and recreational areas of service delivery, ensure relevant service responses are initiated and implemented.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.