

Fairview Care 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:	Fairview Care Limited
Premises audited:	Fairview Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 May 2016 End date: 12 May 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:	47

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

Fairview Care is a privately owned facility which is co-located on the grounds of Fairview Village. Fairview Care facility offers both rest home and hospital level care services for up to 47 residents.

This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, a family member, management and staff. Neither the general practitioner (GP) nor nurse practitioner were available for interview on the day of audit.

The facility management team consists of a facility manager, a clinical manager and an administrator. The management team report to a board of trustees lead by the chief executive officer. There are experienced and skill staff working at the facility.

There were no improvements required from the previous certification audit. Two areas identified for improvement from this audit relate to interRAI assessments not being completed on admission and hard copy policy and procedures not being up to date.

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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Services are provided in a manner that is respectful of residents' rights and acknowledges cultural and individual values and beliefs. Interpreter services are used when required. The sharing of information with residents and family/whānau is well documented.

The service has a complaints management system in place which meets the standard and legislative requirements. 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.		Some standards applicable to this service partially attained and of low risk.
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Fairview Care has an up to date business plan which covers all aspects of service delivery planning. The business plan is reviewed annually at board level to ensure service planning and coordination meets the needs of residents.

The facility has three members in the management team who are all experienced in the roles they undertake. The facility manager has overall responsibility for service management and she is supported by a clinical manager, who is a registered nurse, and an administrator. Management are supported by staff who are experienced in the age care sector.

The service has quality and risk management systems which are understood by staff. Quality management reviews include an internal audit process, complaints management, incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff and residents and family/whānau as appropriate. Corrective action planning occurs as required.

Good human resources practices are implemented. The staffing skills mix is appropriate for the level of care and services provided. Every shift is covered by a registered nurse and at least one staff member who holds a current first aid certificate.

As confirmed during resident and family/whānau interviews, the services provided meet residents' needs.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Services are provided by suitably qualified and skilled staff to meet the needs of the residents. Timeframes for the development and review of the long term care plans are met. Short term plans are developed and implemented when there are changes in the resident's needs that are not addressed on the long term care plan. Assessments are completed for falls risk, nutritional status, continence and pain.

The general practitioner reviews all residents medically at the required timeframes and more frequently as necessary. A family member interviewed reported that care plans that the service is managed in a manner that is professional and caring.

The service has a planned activities programme to meet the recreational needs of the residents. Residents are encouraged to maintain links with family and the community.

A safe medication system was observed on the day of the audit. The registered nurses have completed comprehensive medication competencies to perform this role.

The residents` nutritional requirements are met by the contracted service provider and preferences and special diets can be arranged. All staff who prepare meals are experienced and meals are prepared from a four week menu plan which has been approved by the qualified chef and a dietitian.

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 building warrant of fitness. There have been no changes made to the building footprint 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.
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There are no restraints in use at the time of audit. Policy describes enablers as being voluntary. There are three enablers being used to assist residents to maintain independence at the time of audit. Staff education related to restraint minimisation occurs during orientation and is included in the annual education planning process.

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 management system inclusive of surveillance is appropriate for the nature of this service. The two registered nurses who are the infection control co-ordinators collate monthly surveillance data and report to the manager. Where there are any trends identified action is implemented. The infection surveillance results are reported to staff at the staff monthly meetings. Expertise is available and can be sought as required.

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	14	0	2	0	0	0
Criteria	0	37	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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>Complaints management is implemented to meet policy requirements. The complaints register sighted was up to date and identifies that at the time of audit there are no open complaints. Two complaints were received by the Health and Disability Commissioner since the previous audit. One on the 10 November 2015 and one on 16 September 2015. Letters for both complaints were sighted showing they have been fully closed with no ongoing investigations required. One follow-up recommendation has been put in place.</p> <p>The manager confirmed complaints management information is used as an opportunity to improve services as required. One example relates to food temperatures and all follow up actions are fully documented with the resident and their family/whānau being fully informed and happy with the outcome.</p> <p>Complaints processes are explained during the admission process as confirmed during resident and family/whānau interviews.</p> <p>Staff verbalised their understanding and correct implementation of the complaints process. Complaints are a standing agenda item for staff, management and board meetings.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>As identified in policy, the service ensures that full and frank information is shared with residents and family/whānau as appropriate. Information sharing was identified in the residents' files reviewed and confirmed during resident and</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>family/whānau interviews.</p> <p>Management confirmed that interpreters would be used as required to ensure residents and family/whānau have a full understanding of issues discussed.</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>Policy is in place and implemented related to business and quality planning. The organisation's vision, mission statement, values and scope of service are clearly documented. The business plan is reviewed annually by the five board of trustee members and was updated for the 2016 year. The organisation's goals and direction are described in the business plan. Goals and objectives set cover all aspects of service delivery. The people responsible for ensuring the goals are met was clearly identified and key performance indicators are in place. Management report bi-monthly to the board who monitor the degree to which each goal is progressing. Quality and risk planning details show the risks, current controls and ongoing actions taken to limit risk.</p> <p>On the day of audit, the facility had 100% occupancy, there were five rest home level care residents and 42 hospital level care residents.</p> <p>The management team at the facility consists of the facility manager who oversees all aspects of service delivery at the care facility. She is supported by a clinical manager who is a registered nurse with a current practising certificate, and an administrator. There have been no changes in the management team since the previous audit. Members of the management team attend professional education forums to ensure their skills and knowledge are maintained. The job descriptions sighted identify the authority, accountability and responsibility related to the role each person undertakes.</p> <p>Interviews with residents and family/whānau members confirmed management operate an open door system and that they can speak with a member of the team when they wish. No negative comments were made regarding services provided.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>PA Low</p>	<p>Staff confirmed during interview that the quality and risk management systems documented are understood and implemented during service delivery. These processes include regular internal audits, incident and accident reporting and analysis, health and safety monitoring, infection control management and data recording and complaints management processes. If an area of deficit is found, corrective measures are put in place to address the situation. For example, it was noted that several residents had decreased levels of the protein albumin (hypoalbuminemia). An improvement team was set up and a project was undertaken to address this. A documented plan of action was followed. Measurable indicators were included and over a six-month period resident protein</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>albumin levels were monitored. The results show an improvements have occurred. This was achieved by ensuring food offered for snacks, such as sandwiches, were high in protein. This process is clearly documented with continued follow up being undertaken and reported against.</p> <p>All quality data collected is shared with staff as sighted in meeting minutes and confirmed during staff interviews. The quality data results are reported to staff in a manner that is easily understood and shows comparisons from previously collected data. Quality data information is used by management to inform ongoing service planning and to ensure residents' needs are being met. Corrective measures put in place are evaluated during monthly staff meetings.</p> <p>Residents' meetings, annual multidisciplinary meetings for individual residents and satisfaction surveys are all forums used to indicate resident satisfaction of services offered. All service delivery issues are discussed and followed up as required. Staff verbalised quality improvements and how they have been embedded into everyday practice.</p> <p>Policies and procedures are managed by an off-site provider. Not all the hardcopy of policies and procedures which are accessed by staff were up to date.</p> <p>Actual and potential risks covering all aspects of service provision are identified and documented along with the hazard register. These documents are monitored by the health and safety committee with representatives from across the spectrum of the workforce. Newly identified hazards are documented and reported at board level, with staff, residents and visitors as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p> <p>Residents and families/whānau interviewed confirmed they are happy with the services provided.</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</p>	<p>FA</p>	<p>Policy is implemented by the service in relation to reporting, recording and monitoring adverse events. The service records all incidents and accidents on a specific form. Any follow up required is undertaken in a timely manner and outcomes are monitored by management. Staff interviewed confirmed they report and record all incidents and accidents.</p> <p>Documentation confirmed that information gathered from incidents and accidents are used as an opportunity to improve services where indicated. Incident and accident information is reported at staff monthly meetings as confirmed in minutes sighted. The review of residents' files showed that family/whānau are informed of all incidents or adverse events. This was confirmed during interview with one family/whānau member.</p> <p>The clinical manager and two RNs confirmed their understanding related to the obligations in relation to essential notification requirements including pressure injury reporting under Section 31 of the Health and Disability Services (Safety) Act 2001.</p>

choice in an open manner.		
<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>	FA	<p>Policies and procedures identify human resources management practices that reflect good employment practice and meet the requirements of legislation are implemented by the service. Job descriptions clearly described staff responsibilities and accountabilities. The six staff files reviewed showed that staff have completed an orientation programme with specific competencies for their roles. Staff annual appraisals are up to date.</p> <p>There is an annual education calendar in place for on-site education which is undertaken. This covers all aspects related to care provision. Education included regular staff attendance at off-site presentations and all staff confirmed during interview that they are supported and encouraged to undertake a wide range of education. The RNs are registered at Waitemata DHB under a professional development and recognition programme (PDRP) to ensure their knowledge and skills are maintained to an expected level to meet the requirements of the Nursing Council of New Zealand in regards to maintaining their annual practising certificates and to gain recognition of the level of nursing skills they have reached. The healthcare assistants are encouraged to undertake recognised aged care educational papers. (Five of the six healthcare assistants interviewed have completed advanced age care education papers, including dementia care).</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.</p> <p>Resident and family/whānau members interviewed identified that residents' needs are met by the service in a professional manner.</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>	FA	<p>Policy related to staff skill mixes and experience is reflected in the roster and meets contractual requirements. Every shift is covered by a RN and at least one staff member with a current first aid certificate.</p> <p>A review of the roster showed that staff are replaced when on annual leave or sick leave. With the exception of one staff member, staff interviewed confirmed they have adequate staff on each shift to allow all tasks to be completed in a timely manner and that residents' needs are met. This is supported by resident and families/whānau interviewed. The concern raised by the staff member was followed up by the auditor and copies of the roster for the day in question were reviewed. The roster confirmed there was no decrease in staffing levels. One RN was off sick and was replaced by a bureau RN. (Documents sighted).</p> <p>The clinical manager works Monday to Friday and is on call. There are dedicated kitchen, laundry and cleaning staff. A newly appointed activities coordinator works five days a week.</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 policies are accessible to guide staff as required. The sighted policies meet legislative and best practice guidelines. Medications are managed by the registered nurses and are overseen by the clinical manager. All registered nurses have completed annual medication competencies.</p> <p>Medicines are received from the contracted pharmacy in a pre-packed delivery system. Medication are checked for accuracy by the registered nurses. The medications are stored in a locked medication room. There are two medication trollies used for the medication rounds and these are locked in the medication room when not in use. The medication room has keypad access. Controlled drugs are checked weekly by two registered nurses. A signature list is available to verify signatures if needed. There is a clear process for any medication/incident events.</p> <p>The medication records reviewed have been reviewed by the GP three monthly or more often if required. All medications are prescribed appropriately and computer generated by the pharmacy and reviews are acknowledged. Six monthly pharmacy audits are performed. A system is in place for medication returns to the pharmacy. These are recorded and monitored. The medication fridge is temperature monitored daily. There are no residents that self-administer medication. A policy is in place if required.</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>FA</p>	<p>The food service for Fairview Care Ltd is managed by a contracted service provider based at this facility. A qualified chef is employed to facilitate the food service for the residential care service and for the retirement village. Food is prepared and is transported to the residential care service at appropriate times of the day. A new transportation system is currently being purchased with new trollies which can transport hot and cold foods simultaneously.</p> <p>The staff and trained kitchen-hands give out the tray prepared meals and staff assist residents with their meals. Choices are available on a daily basis and a menu is completed by/or for each individual resident. The menu is displayed daily. Menus are four weekly planned and the chef follows a menu plan appropriate for the needs of the elderly or disabled. Policies and procedures and guidelines are available. On level one there is a kitchen. The kitchen-hands assist with transportation of food from one floor to the other, preparing breakfast, dishes from morning and afternoon teas, and making up beverages or alternative calorie drinks for the residents. The main meal dishes are done on level 3 main kitchen. Additional foods are available over the twenty four hour period.</p> <p>The dietitian is available on a referral basis. All staff involved in food handling have completed relevant training. The contracted chef is responsible for all food procurement, production, preparation, storage, transportation, delivery and disposal of the food service and this complies with current legislation and other requirements. An external annual audit has recently been performed in February 2016 with no areas requiring corrective actions.</p>
<p>Standard 1.3.6: Service</p>	<p>FA</p>	<p>Support and care is individualised and focused on achieving desired outcomes/goals set. The registered nurses and healthcare assistants 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 as</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>able. The residents interviewed reported satisfaction with the care and services provided.</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. The registered nurses ensure the GP is kept well informed of progress.</p> <p>The service has adequate stocks of wound/dressing and continence products to meet the current needs of the residents. The care plans demonstrated interventions that are consistent with the resident's needs being able to be met. Observations on the day of the audit indicated residents are receiving appropriate care as per the interventions documented in the care plans sighted. The registered nurses are allocated a number of residents from admission to be responsible for and to ensure their respective assessed needs are effectively met.</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>The activities programme ensures resident's individual motivational, recreational and cultural needs are recognised. The activities co-ordinator has been recently appointed to this role. The activities co-ordinator assisted with the activities programme prior to commencing this position.</p> <p>Each resident is assessed by the activities co-ordinator on admission. The residents have the opportunity to maintain interests, choices and activities in a continuing care environment. The weekly programme is displayed in three places around the facility. Each resident receives a copy for their own room. Residents and families can access the information displayed. The activities co-ordinator maintains attendance records. The individual activities plans are reviewed six monthly or earlier if required. The co-ordinator is aware that resident participation is voluntary and this is respected.</p> <p>Residents are encouraged to maintain links with family and the community. The service does not have a van for external outings but an appropriate service provider can be utilised by arrangement for outings such as for a shopping trip. A hairdresser is available weekly by appointment on site. A Chaplain is available and a service is held every two weeks. Communion is provided by arrangement. Special days are celebrated. Photographs of recent events are displayed in large phot albums in the lounge.</p> <p>At the time of the audit residents were visibly enjoying the activities in progress during the audit and residents interviewed reported that they enjoy the variety of planned activities arranged. The family member interviewed stated they are encouraged to join in the activities programme at any time.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>Evaluations of care plans occurs six monthly or earlier as applicable. Evaluations are focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the goals. If a resident's needs change or the resident is not responding appropriately to the interventions being delivered then this is discussed with the GP, the resident and the family. Short term care plans are initiated as needed.</p> <p>The healthcare assistants interviewed demonstrated good understanding of short term care plans and reported that</p>

comprehensive and timely manner.		<p>these are identified and information is shared in the handover sessions between shifts. A handover was observed. Progress is also discussed at the multi-disciplinary reviews six monthly.</p> <p>The family member reported that they are consulted when staff have any concerns or when there are changes to the residents` health status/condition. This is documented on the family communication records as evidenced in the records reviewed.</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 building has a current building warrant of fitness which expires on 21 February 2017. Monthly building compliance audit documentation and follow up for any remedial work was sighted. There have been no changes to the foot print of the facility since the previous audit.</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>The infection prevention and control surveillance that is undertaken by the two infection control co-ordinators is appropriate to the size of this aged care setting as demonstrated in the infection control programme. Both staff have attended relevant ongoing education provided by the WDHB infection prevention and control team. All staff are involved. An infection form is completed as soon as signs and symptoms have been identified and given to the registered nurses. Monitoring is described in the infection control plan to describe actions to ensure residents` safety at all times.</p> <p>The infection control co-ordinators complete the monthly surveillance report. Monitoring occurs for any urinary infections, eye infections, upper and lower respiratory infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections as required. The monthly analysis includes comparisons with the previous month, quality improvements and any significant comments. Results are reported to the staff at the various meetings held. Minutes are retained and were available for review. Infection prevention and control is connected to the risk management programme. There has been one outbreak to manage since the previous audit but this was contained to one room and managed well. Records were maintained.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	FA	<p>Enablers are described in policy as being voluntary and the least restrictive option to keep the resident safe whilst promoting or maintaining independence. The facility has no restraints in use. There are three enablers in place at the time of audit as identified in the restraint register. One resident`s file reviewed related to enabler use identifies all process have been undertaken to meet policy requirements. Staff education related to restraint occurs during</p>

Services demonstrate that the use of restraint is actively minimised.		orientation and annually thereafter. Staff interviewed were very knowledgeable about restraint and enabler processes and requirements.
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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 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	PA Low	The off-site provider who maintains the content of the policies and procedures ensures all updates are sent to the facility electronically in a timely manner. Non-clinical policies and procedures are all up to date. However, the hard copy manual of clinical policies and procedures which are accessed by staff does not contain the most recent updated version of all the policies and procedures. The clinical manager stated during interview that she was aware that the staff policy and procedure manual is not always kept up to date.	The clinical manual of paper copies of policies and procedures which are accessed by staff are not all up to date.	<p>Provide evidence that the clinical manual of policies and procedures available to staff are current and contain the most up to date version.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision</p>	PA Low	Resident records were randomly selected for review inclusive of the two residents reviewed in detail. Assessments, planning, evaluations and reviews have been completed in a timely manner but the records	Thirty of 47 residents have	Provide evidence that all residents have

(assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		sighted did not reflect any recent interRAI assessments being implemented.	interRAI assessments completed.	had an interRAI assessment completed. 180 days
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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.