

North Waikato Care of the Aged Trust Board

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](#).

The specifics of this audit included:

Legal entity:	North Waikato Care of the Aged Trust Board
Premises audited:	Kimihia Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 2 June 2016 End date: 2 June 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:	71

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

Kimihia Home and Hospital is owned by a community trust board and provides rest home, hospital, dementia and palliative care services for up to 77 residents.

The audit was conducted against the relevant Health and Disability Services Standards for a residential aged care provider at an unannounced surveillance audit and the services contract with the district health board. The audit process included the review of policies and procedures, the review of staff and resident files, observations, interviews with residents, family/whānau, management, staff and a general practitioner.

There were six areas for improvement identified at the previous full certification audit. Four of these now evidence improvements have been implemented in relation to documenting corrective action plans, staff orientation, staff education and the review of the restraint minimisation programme. There are two that still require further embedding into practice in relation to assessment and evaluation of care. As these ongoing areas for improvement have not been fully embedded into practice, the risk ratings for these have been increased from low at the previous audit to moderate this audit. In addition, there are two further improvement related short term care planning and the complaints register.

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.
--	--	---

There are appropriate processes and communication methods in place for effective communication with residents and families. As required interpreting services can be accessed. Residents and families receive full and frank information and open disclosure from staff.

The service has a documented complaints management system implemented. There are no outstanding complaints at the time of audit.

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 services are governed by a community trust board. The service is managed by a facility manager and a senior management team. The facility manager has appropriate experience and qualifications in the management of an aged care service. The organisation's mission statement, vision, goals and philosophy are clearly documented. The ongoing strategic direction and organisational performance is monitored through the management team and the board.

The current quality and risk system and processes support safe service delivery and include corrective actions. The quality management system includes identification of hazards, staff education and training, an internal audit process, complaints management, data reporting of incidents/accidents and infections.

Policies and procedures are reviewed on a regular basis and reflect current accepted good practice.

The service implements the documented staffing levels and skill mix. The rosters record that there are adequate staff each shift to comply with contractual requirements. Human resources management and education processes are implemented and identify appropriate systems are implemented.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--	--	--

Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Care plans are consistently developed for all residents. Interventions are sufficiently detailed to address the desired outcomes.

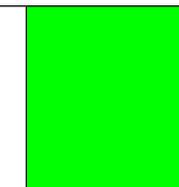
Improvements are required in relation to evaluation of care plans and short term care planning. The previous areas for improvements in relation to assessment and evaluations remain not addressed.

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 consistently meets the required regulations and guidelines.

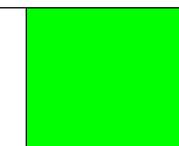
Food services meet the individual food, fluids and nutritional needs of the residents.

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.
--	---	--

There is a current building warrant of fitness.

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 occurs at least annually. Monitoring and review of individual restraint interventions occurs at an appropriate frequency. The restraint register is current.

The previous area for improvement has been fully implemented.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	--	---

Surveillance for infections is conducted monthly. Results of surveillance are collected, collated and analysed to identify any trends and prevent or minimise further infections.

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	1	1	2	0	0
Criteria	0	37	1	1	2	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>	<p>PA Negligible</p>	<p>The sighted complaints policy and process complies with Right 10 of the Code. Complaints management is explained as part of the admission process and is included in the information given to new residents and family/whānau. Complaints forms are on display and easily accessible. Complaints management is included in new staff orientation and included in ongoing training.</p> <p>The complaints registers sighted were not completed and the complaints folder did not contain all complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The service promotes an environment that optimises communication through the use of interpreter services as required to meet the resident's communication needs. The current residents are able to communicate in English. The service has had previous residents who do not speak English, with the example given that staff and the resident's family were able to provide interpreting services for the resident. External interpreters (including sign language) can be accessed as required. Staff education has been provided related to appropriate communication methods for residents with cognitive impairment and non-verbal communication.</p> <p>Documentation of open disclosure following incidents/accidents is evident in the files reviewed. Staff demonstrated knowledge of open disclosure. The residents and families report that staff communicate effectively and that families are informed of any accidents/incidents that have occurred with their relatives.</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>Kimihia is a charitable community owned trust, which provides rest home, hospital, dementia care and palliative care to long term and short stay respite residents. The facility is able to accommodate up to 77 residents. On the day of audit there were 71 residents (21 hospital level of care, 12 dementia level of care and 38 rest home level of care), includes two younger people under the age of 65 and one residents was receiving palliative care.</p> <p>There were five managers as part of the senior management team, this includes the facility manager, clinical nurse manager, clinical administration manager, household services manager and accounts manager. Each role has a job description that describes their roles, responsibilities and authorities. The organisational structure sighted confirms the role and that the facility manager reports to the Board of Trustees. The organisation is governed by a board of trustees. The strategic direction for the organisation was documented and had been approved by the board. The monthly board reports record that the strategic direction, objects and goals are reviewed through the board meetings.</p> <p>The full time facility manager is a registered nurse with a current practicing certificate, who has suitable experience and qualifications for the management of the service. The manager was on leave at the time of the surveillance audit. The facility manager's file confirms they have the authority and responsibility for organisational performance including the day to day running of the business, financial matters, quality and risk systems and human resources. The facility manager's job description and curriculum vitae confirmed that the facility manager held had the relevant clinical and management qualifications. The facility manager's nursing portfolio provided evidence of on-going training and education. The board conducts an annual performance appraisal for the facility manager, with this was last recorded for December 2015.</p> <p>The clinical administration manager (in the acting facility management role in the temporary absence of the facility manager) and clinical nurse manager are both registered nurse.</p> <p>The residents and families report overall satisfaction with the care and services provided at Kimihia.</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</p>	<p>FA</p>	<p>The service has a business plan and quality and risk process in place which covers all aspects of service delivery. Quality planning identifies generalised goals and objectives and the measure used to identify how the controls are effective or responsive to resident needs. This includes quality data collection and analysis to identify any areas of deficit which are addressed using corrective action processes. Corrective actions were sighted related to internal audits, complaints, environmental issues, care planning, and identified risks. The corrective actions sighted evidenced that the corrective actions implemented are reviewed and have been effective, this addresses the previous area for improvement.</p> <p>All findings are shared with the board in monthly reports. The data findings are shared with staff by displaying</p>

<p>quality improvement principles.</p>		<p>in the staff room and at monthly staff meetings as identified in minutes sighted. Quality data information is used to inform the ongoing improvement and planning of services.</p> <p>Policies and procedures are developed by an aged care consultant and are personalised to the service. Any changes or newly introduced policies are shared with staff at the monthly staff meetings. Staff confirmed that they understand and implement documented quality and risk processes. This includes the update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management.</p> <p>Actual and potential risks are identified and documented in the hazard register. The hazard register identifies all known hazards and shows the actions put in place to minimise, isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</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>	<p>FA</p>	<p>The managers and staff understand their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified as identified in policy. This includes the reporting of stage 3 and above pressure injuries. There are records of essential notifications sighted to Worksafe and the Ministry of Health sighted.</p> <p>Incident and accident information is shared with all staff, displayed in the staff room and any corrective actions that have been taken are evaluated. The falls and incident data is reviewed to make improvements when shortfalls are identified.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Staff that require professional qualifications have them validated as part of the employment process and annually.</p> <p>Human resources policies describe good employment practices that meets the requirements of legislation. Newly appointed staff are police vetted upon employment, referees are checked and job descriptions clearly describe staff responsibilities. Staff complete an orientation/induction programme with specific competencies for their roles, such as medication management, as confirmed during staff file reviews and interviews with staff. The orientation records were sighted in all staff files reviewed, this addresses the previous area for improvement.</p> <p>Education records sighted identify that staff education includes on-site planned education with topics being presented by the gerontology nurse specialist and off-site seminars and training days. Individual training records were sighted. The service has developed and implemented a spreadsheet for the training plan and a</p>

		<p>spreadsheet of attended to addresses the previous area for improvement. The service is now able to demonstrate that the system for recording attendance at training ensures all staff are attending the required mandatory training topics.</p> <p>The service has five RNs that are trained in interRAI assessment.</p> <p>The staff who work in the dementia unit are ether in the process of completing or have completed the required dementia care training. The activities staff in the dementia unit have diversional therapy training and training related to the Spark of Life model of conducting meaningful activities with residents who have dementia.</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>The service has a documented process for ensuring staffing levels allow safe and efficient services to be delivered to residents to meet all their identified needs. Rosters sighted identify that the skill mix is based on and exceeds the contractual requirements for staffing levels for rest home, hospital and dementia level of care. The staffing considers the layout of the building in the different levels of care in each of the wings.</p> <p>Staff are replaced for annual leave or sick leave. Staff verbalised that they have sufficient time and staff to complete their required duties.</p> <p>There is specific cleaning, cooking and activities roles to adequately meet the needs of residents.</p> <p>Residents stated all their needs are met in a timely manner.</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>A medicine management system is consistently implemented to ensure that the residents receive medicines in a safe and timely manner. Medication charts are legible and photos are present. Medication charts are reviewed regularly. All discontinued medications are signed for and dated by the GP. Allergies are documented. The controlled drugs register is current. Weekly stocktakes are conducted by the RNs while the six-monthly controlled drugs register check is conducted by the pharmacist. Stock medications are checked weekly.</p> <p>The medicine fridge is monitored and the temperature is recorded daily. The readings are within the required ranges and when readings have variance, this was addressed immediately by the facility manager.</p> <p>Medicine reconciliation is conducted by the RNs when a resident is discharged back to the service. There are no expired or unwanted medications. A system is in place when returning expired or unwanted medications back to the pharmacy. All medications are stored appropriately.</p> <p>The staff administering medications complied with the medication administration policies and procedures as evidenced in the observed medications rounds in both rest home and hospital. Current medication competencies are evidenced in the staff files.</p>

		There are no residents who self-administer their medications, however there are self-administration policies and procedures in place.
<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>	FA	<p>The 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 deliveries. All meals are prepared and cooked onsite. There are current food handling certificates.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. There is evidence that RNs complete the dietary requirement forms on admission and provided a copy to the cook. Additional or modified foods are also provided by the service.</p> <p>Fridge and food temperatures are monitored and recorded daily. The readings are within required ranges and when it is not, this was acted immediately by the maintenance person. Cooked meals are plated from the main kitchen to the dining area. The meals are well-presented and residents confirmed they are provided with alternative meals as per requested. All residents are weighed regularly and there is no evidence of significant weight change in the reviewed resident's files. Residents with weight loss are provided with food supplements and fortified foods.</p> <p>The kitchen staff use safe food practices when preparing meals. A kitchen cleaning schedule is in place.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Moderate	<p>The 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 trends during the assessment are used as the focus of the long term care plans.</p> <p>Conducting pain assessment of residents on regular analgesia and controlled medications remains an area for improvement</p> <p>The previous area for improvement in relation to behaviour assessment for the residents in the dementia unit is now fully addressed and implemented.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote</p>	PA Low	<p>Long term care plans are resident-focused and personalised. There is evidence that continuity of service delivery is promoted. Goals are specific and measurable. Interventions are documented to address the desired goals/outcomes identified during the assessment process.</p> <p>Residents and families are involved in the development of long term care plans as evident in the reviewed resident's files. Staff are informed about changes in the care plans through the hand overs and monthly staff</p>

continuity of service delivery.		<p>meetings.</p> <p>Residents in the dementia unit has a 24-hour management plan in file.</p> <p>Continuity of service delivery is maintained through the use of integrated resident's records, appointment diary, communication book and shift hand overs.</p> <p>Improvement is required in relation to development of short term care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Long term and short term care plans are developed by the RNs. Documented interventions in the long and short term care plans addressed the issues identified during the assessment process. The interventions are sufficiently detailed to address the desired goals/outcomes. The triggers identified in the interRAI assessments are addressed in the long term care plans.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Activities provided are appropriate to the needs, age and culture of the residents. Interviewed residents reported that activities are physically and mentally stimulating. The diversional therapists (DTs) develops 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. Activity plans are well-documented and reflected the resident's preferred activities and interests. A 24- hour activity plan is in place in the dementia unit. A participation log was maintained. The DT referred the residents to the RNs when changes are noted regarding involvement in the activities. Interviewed residents and families said that the activities provided by the service are adequate and enjoyable.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Moderate	<p>Long and short term care plans are developed either the registered nurses or by the enrolled nurses. Changes to the care plans are evident in the reviewed resident's files when the desired outcomes are not met.</p> <p>Improvement is required in relation to documenting the resident's degree of achievement to the intervention, and progress towards the desired goals/outcomes. The previous area for improvement remains not addressed. Short term care plans do not have documented resolution of the acute condition.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>The service has a current building warrant of fitness displayed. There have been no changes to the layout of the building since the last audit and the last trial evacuation that required changes to the approved evacuation</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>scheme.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection control surveillance that is undertaken is appropriate to the size and complexity of the service as shown in the infection control programme. There is external benchmarking with other aged care services.</p> <p>There is monthly reporting of infections. The surveillance data is compared to previous months and previous year's data. The data records that there was an increase in the number of infections with actions implemented to reduce further occurrences.</p> <p>Infection surveillance records and infection control coordinator report that the service had an outbreak of an infection in May 2016. Appropriate standard precautions and transmission based precautions were implemented for this. The service is in the process of reviewing and analysing the data from this outcome for the May infection surveillance data.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service demonstrated that the use of restraint is actively minimised. There are 10 residents using restraints and 2 residents 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.</p> <p>The previous are for improvement in 2.2.5.1 in relation to comprehensive review of restraint practice has been fully addressed and implemented. There is a 50% reduction of restraint use due to this review.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Negligible</p>	<p>The complaints folder sighted contained sections for complaints received by staff, residents, families/friends, members of the public and other health professionals. The folder contained completed complaint forms and the response letters from the manager. These complaints were not logged onto the complaints registers sighted. There was an additional complaint sighted from a family (1 January 2016) that was not sighted in the complaints register or folder. This complaint was sighted in electronic records. These issues were addressed at the time of audit, with the complaints registers now completed.</p>	<p>The complaints register did not contain all complaints; this was addressed at the time of audit.</p>	<p>Ensure the complaints register contains all complaints.</p> <p>180 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process</p>	<p>PA</p> <p>Moderate</p>	<p>The residents receiving controlled medications and regular or “as required” analgesia has no pain assessments in file.</p>	<p>Pain assessments are not consistently conducted for residents on regular or “as required” analgesia and</p>	<p>Ensure that residents receiving controlled medications and regular or “as required analgesia”</p>

and are documented to serve as the basis for service delivery planning.			controlled medications.	have pain assessments. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Two residents chosen for tracer methodology have no short term care plans in place when acute infections are identified.	Short term care plans are not consistently developed when acute conditions are identified.	Ensure that short term care plans are developed when acute conditions are identified. 180 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	Reviewed resident's files have long term care plans in place but evaluations are not resident-focused and do not consistently evident the resident's degree of achievement to the interventions, and/or progress towards meeting the desired goals/outcomes.	Long and short term care plans do not have consistent evidence that indicate the resident's degree of achievement or response to the interventions, and/or progress towards meeting the desired goals/outcomes.	Ensure that long and short term care plans have documented evidence of the resident's degree of achievement to the interventions, and/or progress towards meeting the desired goals/outcomes. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.