

Ativas Limited - Cairnfield House

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 and Disability Auditing New Zealand 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:	Ativas Limited
Premises audited:	Cairnfield House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 August 2016 End date: 12 August 2016
Proposed changes to current services (if any):	Adding medical component to hospital level services.
Total beds occupied across all premises included in the audit on the first day of the audit:	67

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

Cairnfield House provides rest home and hospital level care for up to 67 residents and on the day of the audit, there were 67 residents. A facility manager manages the service. The residents and relatives interviewed all spoke positively about the care and support provided.

The unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, family, management and staff. The service has also been verified, as part of this audit, as suitable to provide medical services under their hospital certification.

The service has addressed 10 of 13 findings from the previous certification audit around implementing corrective actions, staffing of additional hospital level beds, back-up of electronic data, integrated residents' files, admission agreements, care plans, evaluations, activities, medication management, food allergies and menu reviews.

Further improvements are required around open disclosure, analysis and communication of data, and interventions.

This surveillance audit identified that no additional improvements are required.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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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Services are planned, coordinated, and are appropriate to the needs of the residents. Business goals are documented for the service with evidence of regular reviews. A system is in place for the collection of quality and risk data. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme, and education and training, is provided for staff.

Registered nursing cover is provided 24 hours a day, seven days a week. Residents report staffing levels are adequate to meet their needs. The residents' files are appropriate to the service type.

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 low risk.
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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is information gained through the initial support plans, specific assessments, discharge summaries, and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach was evident in the overall residents' files. There is a review by the general practitioner at least every three months.

The activities coordinators implement the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are regular entertainers, outings, and celebrations.

All staff who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission. All meals are cooked on site. Snacks are available.

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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A current building warrant of fitness is posted in a visible location.

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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Restraint policy and procedures are in place. The restraint coordinator maintains a register. The service had two residents using an enabler and no residents with restraint. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

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.
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The infection control surveillance programme is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, and evaluated.

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	16	0	3	0	0	0
Criteria	0	40	0	3	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 forms are available at the entrance to the facility. Discussions with seven residents (five rest home and two hospital) and three families confirmed they were provided with information on the complaints process during their entry to the service. Residents and families also confirmed that they are comfortable speaking with the facility manager and/or clinical manager if they have a concern and that any issue raised is addressed promptly.</p> <p>The complaints procedure is provided to residents and family during the resident's entry to the service. The facility manager maintains a record of all complaints using a complaints' register. Six complaints have been lodged in the register for 2016 (year to date). Complaints are signed off by the facility manager when resolved. One complaint received included input and mediation from the Health and Disability Advocacy Service (link to finding 1.2.3.6).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	PA Low	<p>Policies and procedures relating to accident/incidents and open disclosure identify staffs' responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the accident/incident form and in the residents' progress notes. Not all accident and incident forms and progress notes reviewed across the rest home and hospital identified that family were kept informed. This previous area for improvement remains.</p> <p>Three family (one with family in the rest home and two with family in the hospital) interviewed, stated that they are kept informed when their family member's health status changes or in the event of an accident/incident.</p>

<p>environment conducive to effective communication.</p>		<p>There are contact details of available interpreters. Staff and family assist, as they are able. The information pack is available in large print and is read to residents who require assistance.</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 owned by Ativas Limited and is managed by a facility manager. Care is provided for up to 67 residents across rest home and hospital levels of care with 40 dual-purpose beds. On the day of audit, there were 67 residents (33 rest home level residents and 34 hospital level residents). Seven rest home level residents were in dual-purpose beds and six residents were in double rooms. There was one resident (rest home level) on an ACC contract and one (hospital level) resident on the young persons with disability (YPD) contract. The remaining residents were on the aged related care contract.</p> <p>The service is requesting that the medical component be added to their certificate. This audit verified that the service has appropriate processes, facilities and staffing to provide hospital - medical care.</p> <p>Plans to add a new (20-bed) hospital level wing to the facility are not yet finalised. The facility manager reported that the plans have been modified following input from the DHB portfolio manager. As a result, a second lounge/dining area and ramp access to the outdoor area has been added to the drawings.</p> <p>The owner maintains an onsite office and is present most days, although was not available during the audit. There is a business plan for 2016 that outlines objectives and actions. The purpose, values, scope, direction, and goals of the organisation are identified and regularly reviewed.</p> <p>The facility manager is a registered diversional therapist who commenced employment at Cairnfield House over 20 years ago as a healthcare assistant and has progressed through various roles at the facility since this time. She was appointed to the role of facility manager in September 2013. The owner and a clinical manager, who is a registered nurse (RN) with a current practising certificate and experience in aged care, support her. The facility manager and the clinical manager have maintained at least eight hours annually of professional development activities related to managing an aged residential care facility.</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</p>	<p>PA Low</p>	<p>A quality and risk management programme is being implemented. Policies, procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system ensures policies and procedures are regularly reviewed. Policies are reviewed two yearly unless changes occur more frequently. Policies and procedures have been updated to include reference to InterRAI for an aged care service and current health and safety requirements. New policies or changes to policy are communicated to staff. Interviews with the facility manager, clinical manager/RN and staff (four healthcare assistants, one registered nurse, one cook, one activities coordinator) reflected their understanding of the quality and risk management systems that have been implemented.</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>Quality data is collected for adverse events including falls and skin tears, pressure injuries (if any), and infections. Results of quality data that has been collated, trended and analysed is not regularly communicated to staff. A resident survey and a family satisfaction survey were completed in March 2016. Survey results have not been collated and analysed.</p> <p>Internal audits are completed as documented in the audit schedule. Corrective actions are documented on a corrective action form, where internal audits identify opportunities for improvements and are signed off when implemented. These are improvements from the previous audit.</p> <p>Falls prevention strategies include the use of sensor mats and implementing strategies for frequent fallers. An additional healthcare assistant was recently employed to work the night shift. This has resulted in a reduction in the number of falls during the night shifts.</p> <p>A health and safety programme is in place that meets legislative requirements. Hazard identification forms and a hazard register evidence the three-monthly monitoring of hazard controls. Staff education, which begins during their induction to the service, includes the topic of health and safety. Health and safety representatives have undergone stage three and transitional health and safety training.</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>Individual reports are completed for each incident/accident with immediate action noted including any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes (link to finding 1.2.3.6). Twenty accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations are undertaken if there is a suspected injury to the resident's head.</p> <p>The facility manager and clinical manager interviewed were aware of their responsibility to notify relevant authorities in relation to essential notifications. This had not been required since their last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>Human resources policies address recruitment, orientation and staff training and development. Five staff files that were randomly selected for review (three HCAs, two registered nurses) included evidence of the recruitment process including police vetting, employment contracts, completed orientation, and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice and is developed</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>specifically to worker type. Staff interviewed stated that new staff are adequately orientated to the service. Current annual practising certificates were sighted for the registered health professionals.</p> <p>There is an annual education and training schedule that exceeds eight hours per annum. Careerforce education and training is undertaken by the HCAs. Education and training for registered nursing (RN) staff is supported by the DHB. In-service education topics specifically address palliative cares, and younger persons with a disability. Five of nine RNs have completed their InterRAI training and three are on the waiting list. Competency assessments are in place. Two yearly chemical safety training is in place with evidence of the kitchen staff and cleaning staff attending. Pressure injury prevention management training was last undertaken in 2014 and is on the schedule for September 2016.</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>A staffing plan is documented for the service. This is an improvement from the previous audit. The staffing levels meet contractual requirements. The clinical manager is a registered nurse who is available during weekdays. On-site RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of HCAs supports RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. A robust system is in place for the backup of electronic data. A new server has been installed and all data is stored using cloud-based technology. This is an improvement from the previous audit.</p> <p>Residents' files demonstrate service integration. Information relating to residents is no longer being retained on the clinical manager's hard drive. All documentation pertaining to each resident is held in the residents' hard copy files. This is also an improvement from the previous audit.</p>
<p>Standard 1.3.1: Entry</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services. There is an information</p>

<p>To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>pack available for residents/family at entry. The admission agreement meets current requirements. Exclusions from the service are included in the admission agreement. All admission agreements sighted were signed and dated within an acceptable timeframe. This previous audit finding has now been addressed.</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>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Only inhalers are being self-administered at present. The residents concerned had signed a consent form and all medicines were stored safely. There is one medication room. All medications were securely and appropriately stored. The facility uses a robotic pack system. Medication competent registered nurses, enrolled nurses and senior healthcare assistants administer the medications. Medication competencies are updated annually. The registered nurses are competent in using Niki T syringe drivers for pain relief and administering oxygen if oxygen therapy is required. Medication charts have photo IDs. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Staff sign for the administration of medications on medication sheets held with the medicines and this was documented and up-to-date in all 18 medication signing sheets reviewed. The medication folders include a list of specimen signatures. Medication profiles reviewed were legible, up-to-date and reviewed at least three monthly by the GP. All 18 medication charts reviewed have as needed medications prescribed with an individualised indication for use. The medication fridge has temperatures recorded weekly and these are within acceptable ranges. There are no standing orders. All medication documentation and administration practices meet current legislative requirements and safe practice guidelines as evidenced. This previous shortfall is now being met by the service</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</p>	<p>FA</p>	<p>The service employs a head cook who works Monday to Friday. She also prepares the evening meal and the kitchen assistant cooks it. The second cook works the weekends. There is a kitchen assistant daily. All kitchen staff have current food safety certificates. The head cook is responsible for the procurement of the food and management of the kitchen. There is a small but well-equipped kitchen and all meals are cooked onsite. Meals are served from the kitchen, which opens into the dining room. Residents eating in their rooms have meals delivered on trays with the food covered and kept warm. On the day of audit, meals were observed to be hot and well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Kitchen fridge, food and freezer temperatures were monitored and recorded daily. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six</p>

component of service delivery.		monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets were noted on the kitchen noticeboard, which can be viewed only by kitchen staff. Residents and families interviewed were happy with the meals provided. Previous shortfalls identified around alerting staff to residents' food allergies and menus being review by a qualified dietitian have been met by the service.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	InterRAI assessments, risk assessments and long-term care plans reviewed were completed in a comprehensive manner for all files reviewed. InterRAI assessments and risk assessments are completed on admission and reviewed six monthly as part of the care plan review. All InterRAI assessments sighted informed the care plans. Additional assessments for management of behaviour and wound care were appropriately completed according to need. There was evidence of resident and/or family involvement in all nine files sampled. The service has addressed this previous audit finding.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	All nine care plans reviewed included documentation that meets the needs of the residents, and all care plans had been updated as residents' needs changed. Monitoring forms are completed as directed in the care plan and have been evaluated and if necessary updated by the RN. Family members agreed that the clinical care is good and that they are involved in the care planning. Caregivers and RNs interviewed state there is adequate equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place. Wounds are not always being evaluated according to the timeframes on the wound care form. All wounds have appropriate care documented and provided. There are currently three skin tears, one ulcer, one lesion, one superficial stage-1 pressure injury and two small surgical wounds. Access to specialist advice and support is available as needed. Residents with urinary catheters have catheter care plans. There are no peg feeds at present but the service can accommodate residents with these requirements. Care plans document allied health input. Aspects of the previous shortfalls have been addressed. Wound care evaluation improvements remain unmet.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are	FA	There are two activities coordinators, one works 28-hours over four days and the other works 20-hours over five days including weekends. Both have health assistant backgrounds. On the day of audit, residents were observed being actively involved in the activities programme. A copy of the programme is in residents' rooms and in large print on a whiteboard. The activities coordinators have ensured there are a variety of activities, celebrations and outings to suit all residents including all ages and all abilities. All nine of the resident files sampled had a documented activity plan. This previous shortfall is now being met by the service. Residents have an assessment completed over the first few weeks after admission obtaining a

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>complete history of past and present interests, career, family etc. Resident files reviewed identified that the individual activity plan is reviewed at least six monthly. Church groups visit weekly and Roman Catholics have communion on a Sunday. Seasonal events are celebrated. Residents who prefer to stay in their rooms have one-on-one time, which may involve a chat, hand massage or being read to. The facility has a van for outings. Residents may also use mobility taxis to attend recreational activities.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed were evaluated by the RNs six-monthly or when changes to care occur. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary team, the resident and the family are involved in reviews. There is at least a three monthly review by the GP. The family members interviewed confirmed they are involved in care planning and reviews. The previous shortfall around updating care plans to reflect changes in health status have been met by the service.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location (expiry 1 June 2017).</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 programme is appropriate to the size and complexity of the organisation. Policies and procedures include surveillance procedures and standard definitions. Surveillance infection data is being collected and analysed, but is not consistently reported at staff meetings or at infection control meetings (link to finding 1.2.3.6).</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers and comprehensive restraint procedures. The education and training programme includes regular in-service training on restraint minimisation. Interviews with the care staff confirmed their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had no residents using restraints and two hospital-level residents requesting bedrails as enablers to move safely in bed. Written consent was provided by both residents for the use of their enablers.</p>
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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)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Twenty accident/incident forms were randomly selected for the month of May 2016. Fifteen forms indicated that family had been contacted following an adverse event. Five of the twenty accident/incident forms for three residents stated family did not wish to be kept informed following an adverse event. This information could not be verified in the corresponding residents' files.	Five of fifteen accident/incident forms reflected that family did not wish to be contacted following a minor adverse event. This information could not be verified in the residents' files.	If family do not wish to be kept informed, ensure that these instructions can be substantiated in the residents' files. 90 days
Criterion 1.2.3.6 Quality improvement data are collected,	PA Low	Quality data is collected, evaluated and analysed, although due to staffing changes, the March 2016 satisfaction surveys for residents and for families have not been collated or analysed. Meeting minutes and information posted in the staff room fail to indicate results being communicated to staff. The facility manager reported that due to	i) Quality data results (eg, falls, infections, skin tears) are not routinely shared	i) Ensure results in quality data are communicated regularly to staff; and ii) ensure that satisfaction

<p>analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>		<p>staffing, the resident and family satisfaction survey had not been collated or evaluated. She also reported that one concern documented on a satisfaction survey might have eliminated the need for the resident to contact the HDC advocacy service, if survey results had been reviewed earlier.</p>	<p>with staff; and ii) satisfaction survey results have not been collated and actioned.</p>	<p>surveys are promptly collated, evaluated and actioned in order to address any concerns identified in a timely manner.</p> <p>60 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Wound assessment, wound management and wound evaluation forms are in place. Wound management is clearly documented but wound evaluation is often not evaluated according to the timeframes on the wound care form.</p>	<p>Wounds are not being evaluated according to the timeframe on the wound care form.</p>	<p>Ensure wounds are being evaluated according to the timeframe on the wound care form.</p> <p>60 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.