# Aspen Lifecare 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Aspen Lifecare Limited

**Premises audited:** Aspen

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

**Dates of audit:** Start date: 1 March 2017 End date: 2 March 2017

**Proposed changes to current services (if any):** During this unannounced surveillance audit, a partial provisional audit was conducted. This was completed to increase the number of dual purpose beds by 17 so that the ratio is 11 rest home and 43 dual purpose beds.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 49

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

This unannounced surveillance and partial provisional audit was conducted at Aspen Lifecare Limited (Aspen). The facility has been in private ownership by the current owners since September 2014. Heritage Lifecare Limited manage the facility for the owners under a management agreement. The partial provisional audit was conducted to seek approval to increase the number of dual purpose beds by 17, so that 43 of the 54 beds in the facility are available for dual purpose and 11 are for rest home care.

The audit was conducted against the Health and Disability Services Standards and the organisation’s contract with the Bay of Plenty District Health Board. The audit process included interviews with the facility manager and clinical nurse manager, review of policies and procedures, residents’ records and staff files, observations, interviews with residents, family members, staff members and a general practitioner.

One previous area for improvement raised at the certification audit in 2015 has been partially addressed but further improvements are required. Four new areas for improvement are noted in this report and these relate to: analysis of quality improvement data, completion of staff training, recording all residents identified needs in care plans and review of residents who self-administer medicines.

## Consumer rights

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| --- | --- | --- |
| 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. |

The service provides effective communication that supports residents’ rights, informed choice and individual values and beliefs. Families and residents interviewed confirmed that open communication processes are in place.

The organisation’s complaints process is made available to new residents and their families and information about complaints is available in the facility. A current complaint register is maintained by the facility manager. Complaints are responded to promptly and escalated to senior managers when necessary. Respectful communication is sent to complainants.

## 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 medium or high risk and/or unattained and of low risk. |

Heritage Lifecare Limited (HLL) provides oversight of the facility through an agreement with the owners of Aspen. A senior management team provide leadership and management functions through an operations manager and a quality and compliance manager.

The management agreement includes the provision of a comprehensive quality management system, including document management and control. Documents sighted during the audit were current and available to staff electronically and in hard copy. There are current business and quality and risk management plans. Systems are in place for monitoring the services provided, through weekly management reporting, monthly reporting of clinical indicators, adverse event reporting and internal audits. Actual and potential risks are identified and mitigated. There is a hazard register for the facility.

The HLL human resources management policies are implemented at Aspen and sampling of personnel files confirmed this has been the case since 2014. Staff have completed an orientation programme and have a performance appraisal at three months. A programme of ongoing training is provided which encompasses all staff. Annual performance appraisals are completed and this was confirmed through interviews with staff.

The facility manager develops a weekly roster following a documented process for staffing of the facility. This provides for the allocation of a range of registered nurses, healthcare assistants and support staff, in addition to the facility manager and clinical nurse manager. Current rosters meet the needs of residents in the facility at the time of the audit and there are processes in place to meet the needs of additional numbers of residents receiving a higher level of care should this be approved.

## Continuum of service delivery

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| --- | --- | --- |
| 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. |

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision of care, evaluation, review and exit are provided within time frames that safely meet the needs of the resident and contractual requirements.

All residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident’s needs a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives. A facility van is available for outings.

The onsite kitchen provides and caters for residents with food available 24 hours of the day. Specific dietary likes and dislikes and special needs are catered for. The service has a four-week rotating menu which is approved by a registered dietitian. Resident’s nutritional requirements are met and residents stated that they enjoyed the meals.

A safe medicine administration system was observed at the time of audit. Staff who administer medications have been assessed as competent to do so.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

Aspen is a purpose built aged care facility with a current building warrant of fitness. The facility is on three levels. Floor surfaces and handrails promote safety and mobility for residents. Regular environmental monitoring occurs to ensure the safety of the facility. Regular fire safety checks and evacuation practices occur and evidence of the approved evacuation scheme was sighted.

There are documented procedures for the management of waste and hazardous substances. All staff members have access to this information in training and through information on display in relevant utility rooms and the laundry. Cleaning and laundry processes are described and staff members responsible for these functions follow them.

Residents rooms are personalised, have furnishings, windows, natural light and heating. There are communal spaces and external areas which are safe and accessible. The facility was well maintained, clean, tidy and odour free. Residents were observed to move around the facility independently or with assistance during the days of audit. The additional 17 bedrooms identified for dual use have been appropriately modified so that residents can receive hospital level care in these rooms.

Appropriate security and emergency response arrangements are in place. This includes links with another aged care facility and with the Bay of Plenty District Health Board.

## Restraint minimisation and safe practice

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| 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. |

Policies and procedures provide a framework for the safe use of restraints and enablers within the facility. On the days of the audit there were no restraints or enablers in use.

## Infection prevention and control

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

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

## 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 | 23 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 54 | 0 | 4 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Aspen Lifecare has an appropriate complaint management policy and procedure which meets the requirements of the standard and is consistent with the Code of Health and Disability Services Consumers Rights (the Code), and in particular Right 10.  The complaint management system is used throughout the organisation and is in use at Aspen. The facility manager is responsible for logging complaints on the register and ensuring these are reported and managed. At interview, the facility manager reported that she notifies senior managers of any significant complaints immediately by phone. Complaint data is included in her management reports which go through to support office and the northern operations manager at the end of each week. A sample of these reports were reviewed with the manager and confirmed that reporting occurs as discussed.  The facility manager also maintains the complaint register and this was reviewed, with related complaint documentation, during the audit. It was current on the days of the audit and reflected the actions taken in response to complaints. Correspondence to complainants is respectful and addresses the issues raised. There have been no external complaints since the last onsite audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. Where hospital/consultant appointments were planned, the option of formal interpreters where necessary to support the residents and family were encouraged.  The families/whanau interviewed confirmed that they are kept informed of their relative’s wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents’ progress notes, accident/incident forms and at shift handover. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Aspen Lifecare Limited is a privately-owned facility which is managed by Heritage Lifecare Limited (HLL) under a management contract. All the HLL group systems and documentation are used at the facility as are management reports and senior management oversight. HLL’s general manager attends the Aspen Lifecare monthly board meetings as does the facility manager.  The vision, mission and values of the facility are documented and on display in the reception area and are included in the business and quality plans. They are reviewed as part of the process for reviewing these documents.  The facility manager has worked in the aged care sector since 2002 and as a clinical manager or facility manager for last 12 years. She has been at Aspen since October 2014 as the facility manager. She has a position description which describes her role and provides her with appropriate authority and accountabilities. The facility manager reports to the northern operations manager and the clinical nurse manager reports to the facility manager at Aspen.  Aspen currently provides rest home and hospital level care (hospital geriatric and non-acute medical) for up to 54 residents. They currently have approval for 28 rest home beds and 26 beds for dual purpose use. On day one of the audit there were 49 residents: 28 residents requiring rest home care – one of whom was a respite resident - and 21 residents requiring hospital level care.  Of the five unoccupied rooms, four were the last in a group of 17 rooms being refurbished and upgraded. These are the rooms for which the owners wish to have approval to change the use from rest home to dual purpose. This will change their total bed numbers from: 28 rest home and 26 dual purpose beds to: 11 rest home and 43 dual purpose beds. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In a temporary absence, the clinical nurse manager will provide cover for the facility manager, with assistance from the northern operations and quality and compliance managers.  The clinical nurse manager has worked at the facility since January 2016 and has a current practising certificate. She has a position description which defines her role and identifies responsibilities and reporting lines. During the audit, she was observed interacting well with residents, family members, the nursing team and other staff.  Resident satisfaction survey results from 2016 were positive about the management of the facility and communication. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | There is a current business plan and a quality and risk management plan for Aspen. Both set out objectives for the facility which are appropriate for an aged care facility. The quality and risk plan is used to guide the quality programme objectives, activities to be undertaken over the year and responsibilities of the facility manager and clinical nurse manager. The quality activities include regular staff, health and safety and other meetings, a calendar of internal audits, reporting and recording of adverse events, management reporting through HLL’s systems, and implementing the organisation’s documented quality management system.  Policies and procedures are available to the facility from the HLL support office where there is a central repository for reviewing and updating all documents and ensuring that only current documents are made available to each facility through the quality and compliance manager.  At interview with the facility manager she described the formal reporting systems. A range of reports were sampled and reviewed with the manager and these have been consistently completed since she took on the role.  The monthly reports are to the quality and compliance manager. These reports include collated adverse event data and information about corrective actions taken to address any trends or system issues identified in this report. A sample of these reports were reviewed. Corrective action plans are being raised in relation to generic issues in the clinical manager’s monthly clinical indicators report. General statements in meeting minutes are referred to as corrective action plans. When internal audits are completed and require follow up, the same type of general statements are recorded in meeting minutes. While there has been some improvement in relation to corrective action planning further work is required in relation to this finding and it remains open.  Records are maintained in relation to quality management activities including:internal audits, health and safety meetings, registered nurses meetings, and staff meetings and the minutes associated with all of these.  Risks are included in the quality and risk management plan and these are appropriate for a facility of the size and scope of Aspen. The facility manager reports on any changes in these risks and any additional management strategies in her weekly reports. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse, unplanned or untoward events on incident/accident forms which are then reviewed by the clinical nurse manager. Information about the adverse event is recorded in the resident’s file with appropriate annotations made, and then is filed in the incident/accident register. All events (incidents, accidents, infections, and any significant events) are collated on a monthly basis. See corrective action in criterion 1.2.3.6.  The event register was reviewed for 2016 / 2017 and there was an appropriate level of reporting and recording of all types of events. Open disclosure is practiced and both residents and their families reported that they were kept informed when events occur.  Policy and procedures comply with essential notification reporting, including health and safety, human resources and infection control. The facility manager demonstrated an understanding of what is required for essential notification reporting. If she requires assistance she is able to contact her operations manager or the quality and compliance manager. Evidence of appropriate essential notification records were reviewed. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | The organisation has well described human resources management systems which include the recruitment and appointment of employees, orientation, training and on-going education, performance development and management, and other good employment practices.  A review of personnel files confirmed that required documentation is maintained and recruitment and selection practices have been followed for staff employed since the current owners have been in place. Appropriate validation of annual practising certificates is occurring, at employment and annually, both for employed staff and for contracted health professionals. All practising certificates were current at the time of this audit. Reference and police-checking occurs during the recruitment process. Confirmation that this has occurred is maintained.  There is a planned education programme which includes modules on core topics required by these standards and the contracts held by this provider. Annual medication competencies, and other competencies are included in the programme. All staff who are required to hold first aid certificate have a current certificate. Other staff members are completing this qualification as is appropriate given their role and location.  The facility manager and administrator maintain a spreadsheet of all training attendance and competency completion and this was reviewed. While the spreadsheet had most training attendance recorded on it, not all training and development was recorded. There were also some areas of learning which had not been addressed in the past 12 months which are a necessary part of the ongoing programme of learning.  There are currently four RNs who are interRAI trained. One of these four has just completed their training and is going through the process of completing their assessments to be confirmed as competent. Another RN is scheduled to attend training in April 2017. The facility was current with their interRAI assessments at the time of this audit.  The facility manager and clinical nurse manager share the planning of staff training and development, with the facility manager having overall responsibility for the annual training programme and the clinical nurse manager undertaking competency assessments and supervision of nursing and health care assistants. Evidence of competency assessments is maintained and these were current for the staff at the time of this audit on the personnel files reviewed.  Staff have three monthly appraisals when they first commence working at Aspen and thereafter annual appraisals. Review of personnel files confirmed that appraisals are up to date and interviews with staff confirmed that they have regular performance appraisals. Staff members also reported having adequate training and education, from a variety of sources. Information about up and coming education sessions was observed on display in the staff room. Results of the 2016 resident and family satisfaction survey indicate that, overall, respondents were satisfied with the capabilities of staff at Aspen Lifecare.  The existing orientation and ongoing training programme includes topics suitable for staff who provide hospital level services. The facility manager demonstrated an understanding of the requirements for training specific to the provision of hospital services in particular. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Twenty four hour registered nursing cover is provided. In addition, there are health care assistants, an activities coordinator, house-keeping and laundry staff, kitchen staff, and other staff members who make up the full complement at Aspen.  The manager completes the rosters for the facility and uses the organisation’s safe staffing procedures to allocate appropriate levels of registered nurses and healthcare assistants to the number of residents and the acuity levels. The facility manager’s weekly report are submitted to HLL’s national support office and show the level and skill mix rostered for the coming week.  The rosters showed sufficient staffing levels and skill mix appropriate to meet the needs of current residents. Staff members interviewed reported that staffing levels are sufficient to be able to provide safe services to residents. Residents and family members who were interviewed reported that they are satisfied with care provided.  Partial provisional audit: Using the safe staffing procedures, the facility manager and operations manager have reviewed their current registered nursing complement and have taken on one new casual nurse in preparation for requiring additional staff and one new permanent part time nurse. The facility manager reported that the roster will be carefully reviewed with each additional hospital level care resident referred to the facility. At interview, she demonstrated an understanding of the need to be able to meet the needs of an increased number of residents with higher acuity. This is consistent with the documented procedure.  Staff members interviewed reported that staffing levels increased when hospital level services were added to the facility in 2015. They know that they can approach the facility manager if they need additional staff in their areas to cope with an increased workload. The rosters showed an additional overlapping shift for a healthcare assistant and a housekeeping staff member in the afternoons, who can now provide assistance. The facility manager stated that this role can be expanded as and when needed as a first step to increasing the rostered staff numbers. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | The clinical services manager and registered nurse described the processes to ensure safe administration of all medications. This included competency requirements, prescribing, recording, the process when an error occurs, as well as definitions for ‘over the counter’ medications that may be required by residents. At the time of audit three residents were self-administering medications. The medications were observed as stored in the residents’ rooms in locked boxes, however two of the three residents did not have documented evidence of three monthly evaluations to support self-administering of medications.  Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in medicine trolleys individually in one of two rooms which are locked when not occupied. A locked cupboard is used for controlled medications and the medicine register was sighted. The clinical nurse manager confirmed the pharmacy was due to complete a six monthly audit of the controlled medications and medicine register. Medications that require refrigeration are stored in a separate fridge with recorded temperatures documented, however temperature recordings documented showed that though temperatures remained within appropriate parameters, seven days prior to audit temperatures were dropping. The clinical nurse manager stated that due to a flat battery, two days prior to audit the recordings were not taken. The battery was replaced at the time of audit (please refer to 1.2.3.8)  The facility has implemented an electronic medication charting and management system. Twelve of 14 medicine charts sighted have been reviewed by the GP every three months and are recorded on the electronic medication management system. Two of 14 medicine charts had not been signed in the electronic medication management system, however documentation reviewed showed evidence that the GP had completed a three-monthly review which included a medication review. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and ‘as required’ (PRN) medications identified had the reason stated for the use of that medication. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident.  There are documented competencies sighted for all staff responsible for medicine management. The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management. There are nine standing orders that are documented and are were reviewed every three months by the GP.  The clinical nurse manager and registered nurse interviewed stated awareness of the possibility of an increase in hospital level care residents and confirmed that current procedures and equipment in place would meet specific requirements of each resident. The clinical nurse manager and registered nurse stated that any new issues would be discussed with management. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings were observed daily and meet the food safety requirements. The kitchen manager interviewed had a very good understanding of food safety management and has completed food safety training (please see criterion 1.2.7.5)  There is a four-week rotating menu that has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.  A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the residents are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.  The kitchen also offers residents a variety of cereals for breakfast, a main option for lunch including a desert and a lighter menu option for dinner also supporting individual residents with different cultural food needs if required. All main meals are supported by morning and afternoon tea which includes home baking.  All meals are cooked from the onsite kitchen, food is transported by transport boxes, lunch and dinner is served in one of two dining rooms with residents having breakfast in their bedrooms. Residents have the option of trays in their rooms throughout the day, however all residents are encouraged to have their meals in the dining rooms to encourage appetites and socialisation.  It was reported at time of audit by a workman on site, and the kitchen and facility manager that the linoleum in the kitchen is due to be replaced (please see criterion 1.4.6).  The kitchen manager stated awareness of the possibility of an increase in residents who are requiring hospital level care and confirmed that existing kitchen equipment and kitchen staff would be adequate to meet the individual food requirements of the residents. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools such as (pain scale, falls risk, skin integrity, nutritional screening and depression scale and interRAI as a means to deficits and to inform care planning. A previous area for improvement required that appropriate assessment tools are completed to serve as the basis for service delivery planning. Evidence was seen in seven residents reviewed. All residents have current interRAI assessments completed by one of three trained interRAI assessors on site. Evidence was seen in seven resident files reviewed of initial assessments on admission. All assessments including wound, challenging behaviours, falls, skin integrity and nutritional screening were completed and/or evaluated, signed and dated within timeframes to meet DHB contractual requirements. Residents and families confirmed their involvement in the assessment process. This corrective action is now closed. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | The service has care plans in place however the seven residents’ files reviewed did not address all the resident’s strategies for reducing and minimising risk while promoting quality of life and independence in the reviewed residents’ files and not all the care plans sighted evidenced the required interventions to allow individualised continuity of care.  The caregivers interviewed demonstrated knowledge about eh individual residents they care for and their needs.  Diversional therapy care plans reviewed demonstrated that the resident’s individual diversional, motivation and recreational requirements are managed. The files reviewed showed input from registered nurses, care and activities staff, medical and allied health services.  The families/whanau interviewed reported they were very happy with the quality of care provided by the service. A previous are for improvement required that all care plans provide evidence describing all required support and interventions to achieve each resident’s desired outcome. While there has been some improvement in relation to corrective action planning, further work is required in relation to this finding and it remains open. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Clinical management policies and procedures on admission include assessments of weight, mobility, ability and/or support required for residents to complete daily activities of living, clinical notes and referral information.  The RN and care staff on the day of audit demonstrated that they knew their residents well and observations indicated residents are receiving care that is consistent with their needs. The residents’ files showed evidence of consultation and involvement of the family/whanau. The residents and family/whanau interviewed reported satisfaction with the care and services provided. The care plans reviewed recorded interventions of residents assessed needs and desired goals, however not all information is identified specifically in the residents’ care plans (refer to 1.3.3.4). The service has adequate dressing and continence supplies to meet the needs of the residents. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme uses a framework to empower the residents to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networks and friendships allowing for ongoing socialisation and developing new interests. The activities staff adapts activities to meet the needs and preference of the residents.  The facility has an activity co-ordinator who is new to this role and works Monday – Friday (7 am to 3.30 pm or 8 am to 4.30 pm dependent on the activity), and is supported by an assistant who works Tuesdays 7 am to 4 pm. Both roles are supported by long term and committed volunteers. The activities staff advertises the upcoming activities on the calendar which is delivered to each resident’s room and displayed on the notice board throughout the facility. The activities calendar is also emailed to family/significant others. Regular activities include daily newspaper reading and different types of exercises, church services, regular visiting entertainment and regular trips out with the support of the facility van. The residents also partake in regular community activities such as shopping. Residents have also facilitated regular activities/groups on the weekends. There are specific men and lady’s activities/outings including a newly established breakfast club and a newsletter which is currently been developed. Three monthly resident meetings occur. Residents are supported to attend by an attending community based advocate. All public holidays and special events are celebrated. For residents who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The care staff interviewed stated that they have access to activities to support residents after hours and on the weekends. Staff throughout the day continue to promote social interaction by inviting and encouraging all residents to join in activities together in the main lounges.  The residents’ files reviewed have activities and social assessments that identify the resident’s individual diversional, motivational and recreational requirements The goals are updated and evaluated in each resident’s file three monthly. Daily activities attendance sheet records are maintained for each resident and are assessed and reviewed based on the enjoyment and interest of the resident.  All residents and families interviewed stated that they were happy with the activities on offer and families and visitors felt included when they visited. Residents and families stated that they had privacy when visiting with access to different lounges and outside settings. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The seven residents’ files reviewed had a documented interRAI evaluation that was conducted within the last six months. Three interRAI assessments remained completed but in draft as the RN remains in training and awaiting assessor sign off. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.  A previous area for improvement required that all care plan evaluations indicate the degree of achievement toward meeting goals set. Evidence was seen of residents’ changing needs documented in the care plans reviewed. Residents whose health status changes, and/or who are not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans were sighted for wound care, infections, changes in mobility, food and skin care. The medical and nursing assessments of these short-term care plans are documented in the residents’ progress notes. The care staff interviewed demonstrated good knowledge of short term care plans and reported that they were reported and discussed at handover.  Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident’s condition.  This corrective action is now closed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are documented processes for staff members to follow when handling waste and hazardous substances. These were available in the laundry and in the housekeeping staff members’ flipcharts held on their trolleys and are on display in the sluice rooms. The policy and procedure manuals were in each of the nurses’ stations and available electronically.  Hazardous substances and chemicals were stored securely when in use, when stored, and when in transit for disposal. Material safety data sheets were available for housekeeping and laundry staff relevant the products in use in the facility. Staff members from the housekeeping and laundry team were interviewed and stated that they had received training both on which products to use and how to use them.  Staff have adequate supplies of personal protective equipment (PPE). This includes for routine use, for specialist cleaning and during outbreaks. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility has a current building warrant of fitness which expires on 26 February 2018. All associated checks and monitoring are occurring in relation to the warrant of fitness.  Partial provisional: Aspen is a purpose built aged care facility, on three levels. The main facility is on the top level, which is level two. There are six rooms on a lower level - level one. These rooms are occupied by more independent residents who require rest home level care. The lowest level, the ground level, is a large activities room with an indoor bowling green, darts board and room for other activities equipment to be stored.  There are corridors with handrails and low rolling resistance flooring throughout the facility, both of which promotes independence and mobility for residents. There is a functioning lift which is maintained and operates to all three levels, as well as internal and external stairs. Both sets of stairs are well lit, in good repair and have intact treads.  The facility has a shaded deck with access to a lawn and garden area at the back and end of one wing. There is also another smaller garden area adjacent to murals on the outsides walls which are enjoyed by the residents. Gardens have ramp access and seating.  Currently there is sufficient equipment to meet the needs of the existing numbers of residents requiring hospital level care. The facility manager has discussed equipment needs with the northern operations manager and a new standing hoist has been ordered to replace the existing one at the facility. Additional equipment needs have been identified by the clinical nurse manager and are pending the approval of further dual purpose rooms. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of toilet, showers and bathing facilities to meet residents’ needs. There are six residents’ bedrooms on level one and they share one shower and two toilets on this floor.  The remaining six showers and nine toilets are all on level two and are shared by the residents in 46 of the remaining 47 rooms. One bedroom has an ensuite bathroom. This can be shared by the residents in the two adjacent rooms but is currently used by only one resident.  The proposed reconfiguration to increase the number of dual purpose beds by a further 17 rooms has involved the refurbishment of one bathroom. It was previously a separate small shower and large toilet alongside to one another. The now completed bathroom has a partial wall between the shower and toilet to allow privacy but also sufficient space for a shower chair, commode or other assistive equipment a resident may need. Two other bathrooms have been relined and upgraded, without making structural changes.  Separate toilets identified for staff and visitors are also available. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Rooms are a consistent size throughout the facility. Doorways and corridors are sufficiently wide to accommodate the resident being moved if this is necessary.  Observed during the audit were residents’ personal items and furnishings of their choice in their bedrooms. Residents’ personal preferences were respected by staff members in where and how they wanted items placed in their rooms.  There are 17 bedrooms which have been identified as being suitable for the provision of hospital level care, if an increase in the number of dual purpose beds is approved. The doorways of all these rooms have been widened and built in cabinetry removed and replaced with free standing furniture, or the resident’s own furniture. This is to allow for the larger doors and doorways and for additional equipment if and when this may be needed.  Rooms can accommodate mobility equipment and hospital beds for residents who require hospital level care. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is one large dining room / lounge area within the facility that takes advantage of the view of Tauranga harbour, which residents reported they enjoy. This lounge is also used for many of the activities in the facility. There is another room used as a dining room for some of residents who receive hospital level care. This is at the opposite side of the facility adjacent to the wing where the rooms currently used are for residents receiving hospital level care.  Both rooms can accommodate residents and their mobility equipment either independently or with assistance. Adjacent to the reception desk and main entrance are two smaller sitting alcoves which were used by residents at different times throughout the days of the audit. These are comfortable areas where residents were able to observe the comings and goings, wait for visitors and have access to the external areas of the facility.  As noted in Standard 1.4.2, there is an activities room with a darts board and large indoor bowling green on the ground floor of the facility. Both of which are used regularly. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Staff members from the laundry and housekeeping teams were interviewed. Both reported that they check the effectiveness of their cleaning as they complete tasks during their shifts. Both staff members have a checklist of the tasks they complete on a daily basis and any issues are recorded in a communication book which every member of the team uses.  Internal audits of the laundry and cleaning services are conducted three times a year with the most recent audit completed in January 2017. This was reviewed. Copies of the internal audits of cleaning and laundry services are sent to the health and safety committee and are discussed at their meetings. The most recent audit identified some areas for improvement as well as areas of compliance. (See corrective action 1.2.3.8)  Results of the 2016 resident and family satisfaction survey indicate that most respondents are satisfied with the cleaning and laundry services at the facility. During the days of the audit the facility was in a tidy, clean and well-presented state. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Staff members receive training in fire safety, evacuation of the facility and preparation for emergencies and security arrangements at orientation. There are fire evacuation practices every six months and the annual training includes a refresher on the aspects of this training. Review of personnel files confirms that staff members have attended the scheduled training. A range of staff members from different parts of the facility were able to describe these procedures.  There is an approved evacuation scheme for the facility (sighted) and the current refurbishment has not required any changes to the evacuation plan. Copies of the evacuation plan are on display throughout the facility and fire suppression equipment is available throughout. There is a sprinkler system in the building. Both fire suppression equipment and the sprinkler system are monitored and maintained through the building warrant of fitness schedule monitoring.  There are alternative energy and utility supplies available on site. The cook maintains adequate supplies of food to cope in an emergency and there is a large (approximately 1000L) water tank on the property. Emergency response kits are maintained around the facility with additional bottled water stored in them. These are monitored regularly. All aspects of emergency preparedness were compliant with HLL’s systems. The facility manager and another staff member attend local emergency planning and response meetings run by the District Health Board. Their emergency response plan is available using HLL’s generic plan and procedures, as they are required to do.  Staff members were observed responding promptly to activated call bells during the audit. The call bells have three different settings to allow for low, medium and urgent calls. The facility manager described a new call bell system which will be installed by the end of March 2017 and will allow electronic monitoring of call bell activations and how quickly they are responded to. It will also have pagers for staff to wear and will record the room and location of the call to allow staff to go directly to the person requiring assistance.  The facility manager described the security arrangements. All external doors are locked each evening at approximately 5pm. There is a doorbell at the front door for family members to gain access. There is appropriate monitoring of the external doors during the evenings and overnight by afternoon and night shift staff. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms, lounge/ dining and other rooms used by residents have opening windows with safety latches. This allows for windows to be opened and allow fresh air to circulate. Bedrooms have large external windows which allow natural light and have curtains which are in good order and provide adequate shade and coverage of the windows.  The facility has electric wall mounted heaters in the hall ways and in bedrooms. There are fans in the communal areas and doors and, on the days of the audit windows were opened to allow air to circulate.  Residents and family members interviewed reported that they are satisfied with the facility and their surroundings. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.  The infection control coordinator is the registered nurse. This person was not available for interview at the time of audit. The infection control coordinator holds accountability and responsibility for following the programme in the infection control manual. The infection control coordinator monitors for infections, by using standardised definitions to identify infections, surveillance activity, noting changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at staff meetings. If there is an infectious outbreak this is reported immediately to staff, management and where required to the DHB and public health departments.  The clinical nurse manager reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one to one, at shift handover, in short term care plans and in resident’s documented progress notes.  A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. Residents who have infections are encouraged to stay in their rooms if required. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manually are reviewed annually. A previous area for improvement required that all residents have completed specific forms documented in policy related to the use/need of antibiotics. All residents prescribed an antibiotic showed evidence of documentation in the GP notes, Infection identification form and Infection data care plan identifying the need for an antibiotic as per policy. Documentation showed evidence of evaluation and closing of care plan as required. This corrective action is now closed. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | All staff are required to take responsibility for surveillance activities. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents’ safety. The infection control coordinator completes a monthly surveillance report. The service monitors skin and soft tissue wounds, pressure injuries, urinary tract infections, oral, eyes, ear, and gastroenteritis infections. Antibiotic use is also monitored. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infection. This information is fed back and discussed in management, staff and where appropriate, family and resident meetings.  The monthly reports identify one resident who is chronically unwell and frequently requires antibiotics. Short term and long term care plans sighted evidenced interventions in place to reduce and minimise the risk of infection. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | HLL has appropriate policies and procedures to meet the requirements of the restraint minimisation and safe practice standard. A restraint free environment is in place and similarly no enablers are used. Residents are assessed for their needs in relation to mobility equipment, any falls risk and any other support needs which may be relevant.  Training in restraint policies and procedures, is provided for all staff. Review of personnel files and the training spreadsheet confirms that this training has occurred. The facility manager reported that there are no restraints in use and the health and safety minutes and clinical indicators reports confirmed this.  No residents were observed with restraints in use and all residents using mobility equipment were doing so independently and safely. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | A monthly clinical indicator report is submitted to the HLL quality and compliance manager. Complaints are included in these monthly reports. They are also included in the manager’s weekly reports to HLL support office and the northern operations manager. Records of these reports were reviewed during the audit. The report format requires that there is collation and analysis of the data, a summary of the data, a description of the events which have occurred and how many residents were involved. However, this analysis was very limited, generalised and is only done on each month’s data without looking at previously trends or periods of time.  A review of the incident/accident log for the past three months identified issues which have arisen for a resident who’s behaviour, due their disease process, is being responded to inappropriately. Another resident has been assessed as being a frequent falls risk and has had a number of falls. There is no evidence that the number and frequency of their falls is being monitored and tracked.  Trends in the data for individual residents are potentially being overlooked and issues are possibly not being identified. See also CAR 1.2.3.8 | There is limited analysis of quality improvement data. Other than analysis of infections, other ‘Clinical indicator’ data is only being analysed on a monthly basis and at a simplistic level. Trends in the data for individual residents are potentially being overlooked and issues are possibly not being identified. See also CAR 1.2.3.8  There is no analysis of data for individual residents over longer periods of time or consideration of all the factors involved in all the events for an individual. This does not allow for the management of risk for individuals, and staff, or for monitoring residents’ changing status over time.  Staff members report that they receive some information about adverse data but only limited information and infreqently. There is no evidence of quality improvement data of any kind being shared with residents. | Quality improvement data is analysed so that meaningful conclusions can be drawn and risks managed effectively. The data is reviewed over longer periods of time than one month.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | A previous area for improvement required that corrective action plans were documented. Evidence was seen of corrective action plans being written in meeting minutes and in the clinical nurse manager’s monthly clinical indicators report. However, these plans were general and non-specific, without any timeframes for completion or follow-up activities which could be found. No other sources of recorded information or notes could be located to indicate that these plans had been fully developed and implemented as is required by this standard. | While some improvement has been made, corrective action plans are still not being created which specifically describe the required improvement, identify a specific plan for addressing the noted deficits, and enable monitoring the plan through to completion. | The organisation has a ‘quality improvement plan’ form. This document is to be used for both corrective action plans and quality improvement initiatives. Start using this document whenever a corrective action plan is required.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | HLL has a comprehensive programme of training and ongoing development which is to be implemented at each facility. This was evident at Aspen with records for the programme available for 2015, 2016 years and the programme being prepared for 2017. Records of training attendance are maintained and transferred to a spreadsheet which allows for analysis of attendance by topic and each staff member. | Review of this spreadsheet identifies that approximately one third of staff have not completed all required topics over the whole year. This includes challenging behaviours training both for people with dementia and due to other causes. Kitchen staff in charge of cooking and kitchen management have completed the required unit standards (167 and 168), this was more than five years ago for the main cooks. There has not been any recent training / refresher education in these topics. See also CAR 1.2.3.6. | Keep an overview of staff completing required, ongoing training and education. Ensure that staff attend the required training and that the training programme incorporates additional topics when these are identified.  180 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There were three residents who were self-administering medicines on the days of audit. The residents had up to date three monthly GP and prescribed medication reviews. However, two of the three residents did not have documented evidence of ongoing assessments to support and identify the residents competency in self-administering of medication. The medications were stored in locked boxes. | Two of three residents had an initial assessment to assess for safe self-administration of medicines, however there is no evidence to support the required three monthly ongoing competency assessments to meet contractual requirements. | To ensure that the facility meets the contractual requirements for residents whom are self-administrating medications.  30 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | It was evident from staff interviewed that they knew residents well. Information required to care for the resident was documented in the integrated notes and in supporting specialist summary letters. GP and specialist referrals were evident, however not all information and interventions required to care for the resident was identified specifically in their care planning. One resident had a requirement for fluid restriction documented by a specialist. One resident with complicated medical and social issues was identified with a weight loss of 9.85 kg in one month. Two residents identified as having a history of challenging behaviours. One resident who identified as affiliating with their Maori culture did not have a specific Maori care plan. The resident when interviewed preferred not to have their culture specifically identified but this was not documented in their care plan. One resident was independent in their self-caring of medical intervention. Families/whanau and GP interviewed stated that they were happy with the cares provided. | All information about assessed and support needs was evident in residents’ files reviewed, however not all information was identified specifically in the long-term care plans for each resident. | All information and required interventions pertaining to the resident is identified in the resident’s care plan and meets the individual’s needs and contractual requirements.  180 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 | Staff were able to verbally express residents’ needs and requirements but this was not always evidenced by appropriate documentation in the planning process. Wound and infection care plans were evidenced. However not all required interventions were shown on the residents’ care plan (refer comment 1.3.3.4) One resident had a fluid restriction documented by a specialist. One resident with complicated medical and social issues was identified with a weight loss of 9.5 kg in one month. Two residents identified as having a history of challenging behaviours. One resident was independent in their self-caring of medical intervention. | While some improvement has been made not all interventions undertaken are identified in residents’ care plans. | Provide evidence that care plans describe all the required support and interventions to achieve each resident’s desired outcome.  180 days |

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

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

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

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

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End of the report.