

Kirsty Schofield

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Kirsty Schofield
Premises audited:	Cornwall Resthome
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 March 2017 End date: 22 March 2017
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	27

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

Cornwall Resthome provides residential care for up to 27 residents who require rest home level care. On the day of audit all beds were occupied. The facility is operated and managed by the owners.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a nurse practitioner.

There has been significant progress relating to quality and risk management since the last audit.

Areas of improvement required from the previous audit relating to quality data; aspects of human resource management; education and competencies; the restraint monitoring form and the required timeframes for the completion of resident documentation have been addressed.

Three requirements remain open relating to ongoing assessments of clinical concerns including pain and post fall assessments; not all resident's care plans are evaluated on a regular basis and do not comprehensively record progress towards planned outcomes and the names and designation of staff making entries into the residents' clinical records are not always clear. There are no new requirements from this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted. Residents and their families reported their satisfaction with the open communication with staff. There is access to formal interpreter services if required.

The complaints register is current and all complaints have been entered. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Cornwall Resthome is privately owned and operated and the owners are responsible for the service provided. A business plan and a quality and risk management plan is in place and was reviewed.

The two owners work in the business, one is the manager and the other is responsible for overall maintenance of the facility. The manager is supported by an administrator and two registered nurses who are responsible for the clinical service.

Quality and risk management systems are in place. There is an internal audit programme. Quality data is comprehensively analysed and corrective actions developed and implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality and staff meetings are held monthly and residents' meetings at least three monthly.

The hazard register evidenced review and updating of risks and the addition of new risks. The health and safety representative has completed an update on the Health and Safety at Work Act (2015) requirements.

There are policies and procedures on human resources management. Staff files evidenced required documentation. An in-service education programme is provided and staff have current competencies. Staff performance is monitored.

The documented rationale for determining staffing levels and skill mix is based on best practice.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents' needs are assessed on admission within the required timeframes. Registered nurses are on duty Monday to Friday in the facility and are supported by care and allied health staff and a designated general practitioner. On call arrangements for support from senior staff are in place. Shift handovers and a communication diary guides continuity of care.

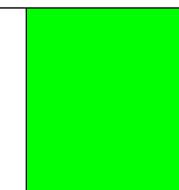
Care plans are individualised, based on a comprehensive and integrated range of clinical information. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning, and that the care provided is of a high standard.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

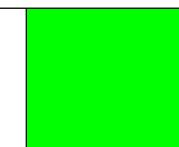
The food service meets the nutritional needs of the residents with special needs catered for. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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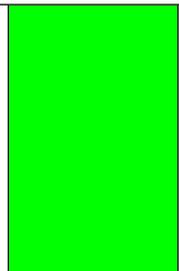
Building and plant complies with legislation. A current building warrant of fitness is displayed. There have been no alterations to the building since the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Policies and procedures for restraint minimisation and safe practice are in place. There are currently no residents using restraints or enablers.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, analysed, trended, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	1	2	0	0
Criteria	0	39	0	1	2	0	0

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

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and there is complaints information and forms available within the facility. A copy of the Code is included in the admission pack for residents.</p> <p>The manager is responsible for the management and follow up of complaints. The manager stated there have not been any complaints since the last audit. Review of the complaints register confirmed this. Staff interviewed demonstrated a good understanding of the complaint process and what actions are required.</p> <p>The manager reported there have not been any investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and families stated they were kept well informed about any changes to their or their relative's status and are advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Residents files have forms, signed by the family indicating when they want to be contacted and what sort of event constitutes families being notified. There was also evidence of resident/family input into the care planning process. Staff understood the principles</p>

<p>provide an environment conducive to effective communication.</p>		<p>of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the DHB when required. Staff knew how to do so and the manager reported this has not been required due to all residents at present being able to speak English.</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>Cornwall Resthome is a family owned and operated business. A business plan and a quality and risk management plan were reviewed and include a mission statement, philosophy, vision, objectives and goals. An organisational flowchart shows the structure and reporting lines within the organisation. The service philosophy and mission statement is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.</p> <p>There are established systems in place which defined the scope, direction and goals of the service as well as the monitoring and reporting processes against these systems.</p> <p>One of the owners is the manager who is experienced in the aged care sector. The other owner is responsible for the internal and external environment. The manager is supported by an administrator and two registered nurses (RN) who are responsible for oversight of clinical care provided to residents. The manager attends the local health care providers' meetings and meetings held by the local DHB, two monthly.</p> <p>Cornwall Resthome is certified to provide 27 beds for rest home level care. On the day of this audit all beds were occupied.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management plan guides the quality programme and included goals and objectives. An internal audit programme is in place and completed internal audits were reviewed. Monthly quality meetings include health and safety, infection control and restraint. Staff meetings are also held monthly. Residents' meetings are held at least three monthly. Meeting minutes reviewed confirmed this. Staff stated they receive and discuss results of quality improvement data including graphs showing any increases or decreases in clinical indicators.</p> <p>The resident and family satisfaction survey for 2016-2017 was reviewed and indicated residents and family are very satisfied with the care provided. Families and the nurse practitioner stated staff provided a high level of care to residents.</p> <p>Completed audits for 2016 and 2017, clinical indicators and quality improvement data were reviewed and evidenced data is being collected, collated and comprehensively analysed to identify trends. Corrective actions were consistently developed, implemented, closed out and monitored showing who was responsible and timeframes for completion. There was documented evidence of follow-up to the action taken and the effectiveness. The deficits from the last audit are now closed.</p>

		<p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures have been reviewed and are current. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery. The interRAI policy includes assessment and re-assessment.</p> <p>Actual and potential risks are identified and documented in the hazard register, including risks associated with human resources management, legislative compliance, contractual risks and clinical risk and showed the actions put in place to minimise or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is responsible for hazards and demonstrated good knowledge. Staff confirmed they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. The manager and RNs review these (See link to 1.3.4.2).</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>The manager and administrator stated they are aware of essential notification reporting to external agencies. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The manager reported there have been no essential notifications made since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources management policies and procedures. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, orientation, education records, reference checks and police vetting. The deficits relating to reference checking and police vetting from the last audit have been addressed.</p> <p>The education programmes for 2016 and 2017 were reviewed and are the responsibility of the administrator. There was evidence of in-service education provided to staff including challenging behaviour training which was a requirement from the last audit. The RNs also attend external education provided by, but not limited to, the local DHB. Individual records of education are maintained. Staff files evidenced education records and current competency assessments for medication and restraint management. Both RNs have current interRAI competencies.</p> <p>Staff have either completed or are currently completing a New Zealand Qualification Authority education</p>

		<p>programme and an external assessor has been engaged to oversee the programme.</p> <p>There is an orientation/induction programme. The entire orientation process can take up to at least a month to complete. Orientation for staff covers the essential components of the service provided. Care staff confirmed they have completed an orientation and all staff had an orientation on file.</p> <p>Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. The manager and administrator are responsible for managing the rosters and consider dependency levels of residents. The minimum number of staff is provided during the night shift and consists of one caregiver. During the week, there is a RN on the floor. The manager is on call after hours for any non-clinical issues and the RN who works four days per week is rostered on for any clinical concerns. Care staff interviewed reported there was adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided.</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>	PA Low	<p>A previous corrective action around the names and designations of service providers making entries into residents' clinical records not being clearly identifiable and / or legible remains in place. Teaching sessions to address this concern have occurred and an alteration in paperwork to allow more space for service providers to record their name and designation, however names and designations of the service providers making the entries remain unidentifiable and illegible.</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</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These</p>

<p>and safe practice guidelines.</p>		<p>medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There was one resident self-administering medication at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and meal satisfaction monitoring records. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>A previous corrective action identifying ongoing assessment of clinical concerns, such as residents pain, are not completed as clinically indicated remains in place. Interviews with the RN, residents, families/ whanau, care staff and the NP, verify the clinical status of residents are assessed on a regular basis and as clinically indicated. However, documentation is not consistently available, to evidence this occurs regularly as clinically indicated.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care, except for that referred to in 1.3.4.2. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision, and was an area frequently mentioned as being of a high standard in interviews. The NP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is of an exceptional standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by two-part time activities officers.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated on an ongoing basis and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include members of the local community coming in to do the morning crossword sessions, participating in activities within Cornwall House and providing entertainment. The activities programme is discussed daily with residents. Interviews and observation verified that residents input was sought about activities they would like and these requests were responded to. Residents are frequently out, attending local events in the region. Residents confirmed they find the programme exciting and rewarding. Family members when interviewed referred to feeling involved, welcomed and being part of the 'Cornwall family'.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>PA Moderate</p>	<p>A previous corrective action remains in place, around care plans not being regularly evaluated.</p> <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>reported to the RN and documented by the RN in the progress notes. Where progress is different from expected, the service responded by initiating changes to the care provided. Formal care plan evaluations are not occurring every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change.</p> <p>Staff, residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes, on a day to day basis.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current Building Warrant of Fitness is displayed that expires on the 11 November 2017. There have been no structural alterations since the last audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented on infection reporting form. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported at the quality meeting.</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>There were no residents using restraint or enablers during the audit. The policies and procedures have good definitions of restraints and enablers. The manager is the restraint coordinator and demonstrated good knowledge relating to restraint minimisation. Staff demonstrated sound knowledge about restraint processes including the difference between restraints and enablers. The restraint coordinator and staff described how they manage challenging behaviour and the use of equipment, such as sensor mats so that restraint is only used as a last resort.</p>
<p>Standard 2.2.3: Safe</p>	<p>FA</p>	<p>The manager and staff understood the safe use of restraint. The restraint coordinator described their expectations relating to this. There is a current and updated restraint register which showed there was one</p>

<p>Restraint Use</p> <p>Services use restraint safely</p>		<p>resident using restraint since the last audit but is no longer using it. Staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. The restraint minimisation policies and procedures are in place and are accessible for all staff to read. Monitoring forms have been reviewed and expanded. Review of the monitoring form for the resident who was using restraint evidenced this resident was viewed at the required times and staff had completed the monitoring form correctly.</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 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Clinical records are clearly legible however the names and designations of service providers making the entry is not identifiable due to the name and designation being illegible. The Manager stated “teaching sessions and a change in paperwork to enable more space to record the service providers name and designation, had addressed the concern following the last audit” and was unaware the issue was ongoing.	The names and designations of service providers making entries into the residents, clinical records are not clearly identifiable and/or legible.	The names and designations of service providers making entries into residents’ clinical records are identifiable and legible 180 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment	PA Moderate	The needs, outcomes and goals of residents are identified via the assessment process and documented to form the basis of care planning. Clinical assessments such as weight, blood pressure, temperature and pulse are now being completed and recorded regularly. Interviews verify the clinical status of residents are assessed regularly and as clinically indicated, however documentation to evidence all assessments, ie, pain, assessment of	Ongoing assessments of clinical concerns such as pain, falls, medication changes, behaviour changes	The clinical status of residents is assessed/reassessed on a regular basis as clinically indicated.

<p>process and are documented to serve as the basis for service delivery planning.</p>		<p>residents' following injury and assessment of residents' behaviour following changes in medication was not sighted. Interviews with RN, care staff, residents, families and the NP verify the documentation is unable to support this is occurring.</p>	<p>are not completed.</p>	<p>90 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Moderate</p>	<p>Resident care is evaluated each day and reported in the progress notes. However, formal care plan evaluations, are not occurring every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Documentation around short term care plans was not consistently reviewed and progress evaluated as clinically indicated. Other plans, such as wound management plans were evaluated each time the dressing was changed.</p>	<p>Documentation was unable to evidence resident care plans were being regularly evaluated. Those evaluations that have been completed do not comprehensively record resident progress towards planned outcomes.</p>	<p>Comprehensive and timely evaluation of resident progress towards desired outcomes are documented. 90 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.