

# Heritage Healthcare Limited

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Heritage Healthcare Limited

**Premises audited:** Karetu House

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 February 2015      End date: 23 February 2015

**Proposed changes to current services (if any):** The audit reviewed two single rooms that are identified as now being used for two residents in each (noting that the rooms were already certified for one resident in each room at the last audit). The number of beds is now confirmed as 43 – previously 41 beds in the last certification report.

**Total beds occupied across all premises included in the audit on the first day of the audit: 43**



# Executive summary of the audit

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## 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

Karetu House can provide care for up to 43 residents. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the District Health Board Contract.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The facility manager is responsible for the overall management of the facility and supported by two registered nurses. Service delivery is monitored. Staffing levels were reviewed for anticipated workloads and acuity with adequate staffing in place.

Three improvements required at the last certification audit around documentation, medication and the call bell system have been addressed.

Improvements are required to the business plan, performance appraisals, competencies related to medication, and repairs to the building.

## 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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Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties and caring for the residents. Information regarding resident rights, access to advocacy services and how to lodge a complaint was available to residents and their family and complaints were investigated. Staff communicated with residents and family members following any incident.

## 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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The service has implemented a quality and risk management system that supported the provision of clinical care and support. Policies were reviewed and the business plan documented for 2014. The business plan was to be developed for 2015. Quality improvement included review of incidents/accidents, adverse events, infections and complaints.

Staffing levels were adequate across the service and interviews with residents and relatives demonstrated that they have adequate access to staff to support residents when needed. Most staff had a performance appraisal completed annually. Policies around human resources were adequately documented and implemented.

An improvement required at the certification audit around documentation in resident records had been addressed.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The assessment, provision of care, review and evaluation of care is provided within timeframes to safely meet the needs of the residents. There is evidence that the services were coordinated in a manner that promoted a team approach and continuity in care. The care plans documented care provision that was consistent with the residents' assessed needs and desired outcomes. Care was evaluated at least six monthly to enable regular monitoring of the resident's progress towards achieving their desired outcomes. When progress is different to that expected, the service responded by initiating changes to the care plan.

Activities are planned and provided to facilitate and maintain the strengths and interests of the residents.

Food and fluids are provided to meet the needs of the residents. The nutritional services take into account the special needs, likes and dislikes of the residents.

A safe medication management system was observed and implemented. There were previous areas requiring improvement to ensure all medicines given are signed for. This is now addressed with evidence of the improvement implemented. There is a new area for improvement related to documenting medication competencies.

## 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.		Some standards applicable to this service partially attained and of low risk.
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There is a current building warrant of fitness in place. There is a planned and reactive maintenance programme in place with issues addressed as these arose. Residents and family described the environment as meeting their needs.

An improvement required at the certification audit around installation of call bells in double rooms has been addressed.

The areas identified as showing exposed particle board and windows that present a danger on the deck when opened are to be addressed.

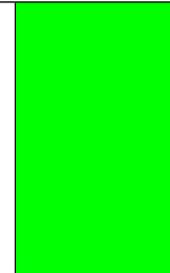
## Restraint minimisation and safe practice

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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Policy identifies that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. There was no recorded restraint or enabler use. Staff undertake appropriate restraint minimisation education and could verbalise their knowledge and understanding of safe restraint management processes, if this was required.

## Infection prevention and control

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



Standards applicable to this service fully attained.

There is monthly surveillance of infections recorded for the rest home and hospital sections of the service. The infection data was recorded, analysed and reported to staff and management. Where trends were identified, strategies to reduce infections are implemented.

## 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)
<b>Standards</b>	0	14	0	4	0	0	0
<b>Criteria</b>	0	46	0	4	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 organisation's complaints policy and procedures was in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and included time-frames for responding to a complaint. Complaint's forms were available in each wing of the rest home and residents interviewed were able to locate these.</p> <p>A complaints register was in place and the register included details of the complaint and that it was resolved. Evidence relating to each lodged complaint was held in the complaint's folder.</p> <p>Two complaints lodged in 2014 were selected for review. There was documented evidence of time-frames being met for responding to these complaints.</p> <p>Residents and family interviewed stated that they would feel comfortable complaining.</p> <p>There have been no complaints from the Health and Disability Commission or other authorities since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alerted staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guided staff on the process to ensure full and frank open disclosure was available.</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Family were informed if the resident had an incident, accident, had a change in health or a change in needs, evidenced in 15 completed accident/incident forms and in the resident files noting that some residents did not have family involved in their lives.</p> <p>Interviews with family members confirmed they were kept informed.</p> <p>Interpreting services were available when required from the district health board. There were no residents requiring interpreting services.</p> <p>The information pack was available in large print and advised that this could be read to residents.</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>Karetu House has a clear mission and philosophy that reflected the needs of residents.</p> <p>The facility can provide care for up to 43 residents for rest home level of care with full occupancy on the day of audit.</p> <p>The facility manager is responsible for the overall management of the facility. The facility manager has been in the role for nine years with a background of 15 years in management roles. The facility manager was supported by two registered nurses who provided clinical oversight of the service.</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>PA Low</p>	<p>A quality and risk management framework was documented to guide practice. The 2014 business plan was documented and reported on through the staff meeting. The 2015 plan had yet to be documented.</p> <p>The service implemented organisational policies and procedures to support service delivery. All policies were subject to reviews as required with all policies current. The facility manager reviewed the policies on a one to two year basis. The service is moving towards electronic copies of policies. Policies were linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies were readily available to staff in hard copy in the office.</p> <p>All staff interviewed reported they were kept informed of quality improvements through monthly staff meetings, with minutes of the meeting mailed or given to staff who could not attend.</p> <p>The organisation had a risk management programme in place. Health and safety policies and procedures and health and safety objectives were in place for the service. A hazard register for each part of the service was documented and hazards were documented as these arose. The hazards for the refurbishing was not documented however the facility manager rectified this on the day of the audit. All areas being renovated were well managed with plastic orange netting in place and signs up indicating where other facilities for residents to use were located. The contractors on site were able to describe health and safety issues and management of the areas to prevent residents and others from being hurt.</p>

		<p>Residents and family had input into the service through monthly resident meetings and annual family satisfaction surveys with general resident satisfaction surveys and food and activity satisfaction surveys. All surveys for 2014 indicated that there was a high level of satisfaction with the service.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, review of falls, medication incidents, wounds and behavioural issues. There was implementation of an internal audit programme noting that improvements identified as being required have a corrective action plan with evidence of resolution of issues documented in meeting.</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>The facility manager was aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. HealthCERT was notified of a missing person who had just been reassessed for further level of care and the district health board and HealthCERT for a resident who had an accident.</p> <p>The service was committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process.</p> <p>Staff received education at orientation on the incident and accident reporting process. Staff understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Fifteen incident reports selected for review had a corresponding note in the progress notes to inform staff of the incident.</p> <p>Information gathered was graphed and shared through the monthly staff meetings with documentation indicating that the results of the analysis of data were used to improve resident care and service delivery. The service completes reports and these were also reviewed for trends.</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>	PA Low	<p>All registered nurses held current annual practising certificates. Visiting practitioner's current practising certificates included the general practitioner and pharmacist.</p> <p>Staff files randomly selected for audit included appointment documentation on file including signed contracts, job descriptions and interview records. There was an annual appraisal process in place with most staff having a current performance appraisal. First aid certificates were held in staff files along with other training records.</p> <p>Police checks were completed for new staff.</p> <p>All staff completed an orientation programme that met the educational requirements of the Aged Residential Care (ARC) contract.</p>

		<p>Caregivers were paired with a senior caregiver for shifts until they completed orientation.</p> <p>Annual medication competencies were completed for caregivers who administered medicines to residents (refer 1.3.12).</p> <p>Staff stated that the training was adequate and they were encouraged to attend training opportunities at Auckland District Health Board. There were folders of attendance included in staff files.</p> <p>Education and training hours exceeded eight hours a year for all staff reviewed.</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>The staffing policy is the foundation for work force planning. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters reflected staffing levels that met resident acuity and bed occupancy.</p> <p>The rosters indicated that there were two registered nurses who worked a total of 45 hours a week.</p> <p>There were adequate numbers of caregivers on all shifts with staff and residents confirming that staffing was appropriate to the needs of residents.</p> <p>There were 23 staff including the facility manager and 14 caregivers. Four other caregivers also completed laundry, cleaning or kitchen duties.</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>	FA	<p>The document control policy identified how health information met legislative requirements and relevant professional and sector standards.</p> <p>Resident information was stored and filed to ensure it is not on public display. The caregivers completed progress note entries each shift with registered nurses and other staff writing in notes as required. The progress notes recorded the date, name, signature and designation of the staff member. The improvement required at certification has been addressed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current</p>	PA Low	<p>The previous audit identified actions required to meet the standards at criterion 1.3.12.6 which was to ensure the medicines administration sheets are fully completed. This has been an improvement implemented and embedded in practice; evidence reviewed shows this issue is now addressed. There is a new area for improvement at 1.3.12.3 to ensure all staff who participates in medicine management are assessed as competent.</p>

<p>legislative requirements and safe practice guidelines.</p>		<p>The medicines were supplied by the pharmacy in a pre-packed administration system. The medicines that are not pre-packed, such as liquid medicines, were individually supplied for each resident. The medicines and pre-packed medicine sheets were checked for accuracy by the RN when they were delivered. The pre-packed medicines and the signing sheets were compared against the medicine prescription. The GP conducted medicine reconciliation on admission to the service and when the resident had any changes made by other specialists. Safe medicine administration was observed at the time of audit.</p> <p>The medicines and medicine trolley were securely stored. There were no controlled drugs. The temperature of the medicine fridge was monitored weekly; these temperatures have been recorded in degrees Fahrenheit and it is suggested that the service use degrees Celsius.</p> <p>All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. Each medicine was signed by the GP and had the required level of documentation to allow safe administration of the medicines. The prescriptions were legible, recorded the name, dose, route, strength and times for administration. When medicines were discontinued, these were signed and dated by the GP. Sample signature verification was recorded for all staff who administer medicines. All of the medicine charts were reviewed by the GP in the past three months. The standing orders are reviewed and signed by the GP in the last 12 months.</p> <p>There were a number of residents who were assessed as competent to self-administer some of their medicines (the majority of these being topical medications). The service's policies, procedures and self-administration guidelines were followed for these residents.</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 menu was reviewed by a dietitian as suitable for the older person living in long term care. The kitchen manager reported that when the menu was developed they received input from the residents, staff and management to develop a suitable menu. The service had a four week rotational menu with seasonal variations.</p> <p>Residents were routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets had these needs met. The kitchen service received a copy of the residents' nutritional profile, with the residents' preference and special diets recorded and updated at least weekly. The residents and families reported satisfaction with the meals and fluids provided. The residents and families also commented on the 'atmosphere' and how 'well the staff served' the meals in the dining rooms.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. The food and storage areas are monitored for temperature. The kitchen staff have had food safety training.</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>The provision of services and interventions were consistent with, and contributed to, meeting the residents' assessed needs and desired outcomes. The care plans were individualised and personalised to meet the assessed needs of the resident. The care plans addressed the physical, psychosocial, spiritual and cultural needs of the residents. The care was flexible and focused on promoting quality of life and encouraging independence for the residents. All residents and family/whanau interviewed reported high satisfaction with the care and service delivery.</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 residents were included in meaningful activities at the care facility and as part of the wider community. There were planned activities seven days a week, with care staff and volunteers assisting with activities on the weekends. The activities programme covered physical, social, recreational and emotional needs of the residents. Residents linking with recreational and social activities in the community were supported.</p> <p>The diversional therapist reported that they gauge the responses of residents during activities and modified the programme related to residents' response and interests. Feedback and suggestions of the activities programme is gained from one to one discussion and residents meetings. The diversional therapist reported the activities were modified according to the capability and interests of the resident, with examples given of how activities such as a fishing trip and a wrestling discussion group for residents with these particular interests. One resident with an interest in weaving is now leading a group related to this.</p> <p>Each resident had a social history and a social/activities plan that documented the resident's history, goals, supports that can be implemented to achieve the goals, community outings, one to one interventions and strengths. The diversional therapist used the assessments to develop an activities programme that was meaningful to the residents. The activities plans were evaluated at least six monthly.</p> <p>The residents and family reported satisfaction with the range and quality of activities offered. The residents and family members report that the activities programme is one the strengths of the service.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The evaluations of care were conducted at least six monthly. Each resident had an evaluation form that documented how the goals have been achieved over the past six months, then a more comprehensive summary on the care plan.</p> <p>Where progress was different from expected, the service responded by initiating changes to the care plan or by use of short term care plans for temporary changes. Short term care plans were sighted in the files reviewed. If the issue requires ongoing interventions, the long term care plan is updated to reflect the change.</p>

		The residents and family/whanau interviewed reported high satisfaction with the care provided at the service.
<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>	PA Low	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 15 March 2015). There have been no building modifications since the last audit.</p> <p>Refurbishment of ensuite and repairing of a deck was occurring on the day of the audit with appropriate signage and tape securing the areas.</p> <p>The lounge areas were designed so that space and seating arrangements provided for individual and group activities with the activity programme offered in the main lounge on the day of the audit. The areas were suitable for residents with mobility aids.</p> <p>Equipment was available with individualised continence products, shower chairs and sensor alarm mats. There was a test and tag programme two yearly and calibration completed annually. Both checks were current.</p> <p>The surveillance audit confirmed the increased configuration of two bedrooms to allow for two residents in each. The number of beds is now at 43. Each shared room had curtains between the beds and a call bell for each resident. The shared room policy guided use of the rooms.</p> <p>There were some doors on toilets/bathrooms that have exposed particle board. These will be replaced as part of the refurbishment underway.</p> <p>There was one bedroom with windows that opened out onto a deck. Both windows could be a danger to residents or others moving around the deck as they were on the respective corners of the building. Neither window had a stay to prevent it being pushed out to maximum capacity.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Staff files and education records confirmed that fire evacuation and emergency training was undertaken six monthly.</p> <p>The approved evacuation scheme is dated 24 July 2000.</p> <p>Inspection of emergency equipment and lighting, fire alarms and sprinklers were carried out monthly by a contracted company. Emergency lighting lasted up to three hours. Smoke detectors were linked to a fire panel located in the manager's office and sprinklers were linked directly to the fire service. The facility manager confirmed there was a gas BBQ available if required.</p> <p>There was food available for at least three days and extra blankets were available.</p>

		<p>All staff had current first aid certificates.</p> <p>Staff were required to ensure doors and windows are securely closed at night.</p> <p>The call bell system was audible throughout the facility and there was a panel to identify where the call had been made. Residents confirmed staff responded in an appropriate timeframe. There were security cameras located in the external areas of the building.</p> <p>All double rooms had call bells installed including the reconfigured rooms. The improvement required at certification has been addressed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The service conducted monthly surveillance for infections, with a quarterly analysis of results. The service used standardised definitions of infections that are appropriate to the long term care setting.</p> <p>The infection and surveillance data for the fourth quarter in 2014 provided an analysis of the number and types of infections. A comparison was made with the previous period, with analysis recorded why there was an increase or decrease in the types of infections. The analysis recorded that the number of fungal infections are down. The analysis recorded that the nursing interventions have been the main contributing factor in the reduction and maintain the lower infection numbers.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There was no recorded restraint or enabler use. The policy identified that if enablers are to be used, these will be voluntary and the least restrictive option to assist residents to gain and/or maintain independence in movement and mobility whilst keeping them safe. The facility manager reported that the service had never required restraint or enabler use. The service had a restraint committee that reviewed the policies and ensured that the process met the standards if restraints or enablers were needed to be used. The staff demonstrated knowledge on restraint minimisation and how to avoid the use of restraint through effective management of challenging behaviours.</p>

## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
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 Low	A business plan with goals was documented in 2014. Review of the plan could be sighted through individual reports for example around falls, medication incidents etc. A regular review of the business plan that accumulates all review of goals would assist the quality programme.	The business plan has not been documented for 2015.	Document a quality/business plan for 2015 that includes goals, actions, accountabilities and timeframes with the plan implemented and reviewed at regular interviews.  60 days
Criterion 1.2.7.5 A system to	PA Low	Most caregivers had completed an annual performance appraisal.	Performance appraisals had not been completed	Review performance for

identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.			annually for the registered nurse, facility manager and three other staff.	all staff annually.  60 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	The medications are administered by senior caregivers. Medication competencies were sighted for 13 staff that assisted with medicine management. There was no documented competency assessment sighted for the RN on duty at the time of audit, though it is the caregivers who were assisting with the medicine administration. The RN demonstrated sound knowledge and competency on medicine management, they researched the implementation of the new medication administration and storage system in May 2014. As the service has implemented an action plan to ensure the RN does have the formal competency assessment undertaken within this week, this is assessed as a low risk.	The RN does not have a documented medication competency.	Ensure there is documented evidence that all staff that assist with medicine management are assessed as competent to do so.  180 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	There was refurbishment of ensuites and toilet/bathroom areas in progress on the day of the audit. The doors to bathrooms and toilets had been identified as requiring repair.	i) Ensure that doors on toilets/bathrooms do not have exposed particle board. ii) Ensure that two windows in one bedroom do not present a hazard to anyone using the deck area.	i) Ensure that doors on toilets/bathrooms do not have exposed particle board. ii) Ensure that two windows in one bedroom do not present a hazard to anyone using the deck area.  60 days



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

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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
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End of the report.