

Oceania Care Company Limited - Woodlands Rest Home & Village

Introduction

This report records the results of a Certification 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 Central Region's Technical Advisory Services 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: Oceania Care Company Limited

Premises audited: Woodlands

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

Dates of audit: Start date: 22 June 2015 End date: 23 June 2015

Proposed changes to current services (if any): This audit has confirmed the appropriateness of the reduction of dementia unit capacity by six beds from 17 to 11 and the increase of rest home beds from 16 to 22 as per HealthCERT request.

Total beds occupied across all premises included in the audit on the first day of the audit: 48



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

Woodlands (Oceania) can provide care for up to 63 residents. This certification audit has been undertaken to establish compliance with the Health and Disability Service Standards and District Health Board contract and to confirm the appropriateness of a decrease of dementia beds from 17 to 11 with an increase in the number of rest home beds from 16 to 22.

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 business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and regional and executive management team. Service delivery is monitored. Staffing levels are reviewed for anticipated workloads and acuity.

An improvement is required to the timeliness of completion of long-term care plans.

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 are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained. The service is located close to community facilities and residents can access these as able.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation's mission statement and vision is displayed and planning includes business strategies for all aspects of service delivery. The management team regularly reviews the business, risk and quality plans.

The quality and risk system and processes supports safe service delivery and includes an internal audit process, complaints management, resident and relative satisfaction surveys, and incident/accident and infection control data analysis. Corrective action planning is implemented with evidence of resolution of issues. Quality and risk management activities and results are shared among staff, residents and family. Reporting processes includes benchmarking with other Oceania facilities.

There are human resource policies implemented around recruitment, selection, orientation and staff training and development. Staffing levels are adequate and residents have adequate access to staff when needed.

The current management team, training programme and staffing rationale is appropriate for the reconfigured beds and no changes are required.

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 systems reviewed evidenced each stage of service provision was developed with the resident and/or family input and coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices.

A sampling of residents' clinical files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan.

Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. The resident self-administering medicines does so according to policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. There is a central kitchen on site and staff that provide the food service. The kitchen staff have completed food safety training.

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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All building and plant complies with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings, floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed.

The dementia unit remains a secure unit with beds reconfigured now part of the rest home area.

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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The restraint policy, procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There were two residents using restraint and no residents requiring enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour had been provided.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. The policies and procedures guide staff in all areas of infection control practice. New employees are provided with training in infection control practices and there is on-going infection control education available for all staff.

Infection control is a standard agenda item at facility meetings. Staff are familiar with infection control measures at the facility.

The infection control surveillance data was sampled through resident records, clinical indicators and collated infection reports. The information sampled confirmed that the surveillance programme is appropriate for the size and complexity of the services provided.

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	49	0	1	0	0	0
Criteria	0	100	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility including a poster outside the door of the dementia unit. New residents and families are provided with copies of the Code as part of the admission process.</p> <p>Staff are provided with annual training around rights and the Code. The clinical staff were observed to implement rights as per the Code in their day-to-day practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.</p> <p>All resident files identified that informed consent is collected.</p> <p>Staff confirmed their understanding of informed consent processes.</p> <p>The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discusses informed consent processes with residents and their families/whānau during the admission process.</p>

		The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files noted that all had appropriately signed advanced directives.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service.</p> <p>Staff training on the role of advocacy services is included in training on The Code of Health and Disability Consumers' Rights with this provided annually to staff.</p> <p>Discussions with family and residents identifies that the service provides opportunities for the family/EPOA to be involved in decisions.</p> <p>The resident files include information on resident's family/whānau and chosen social networks with a communication sheet kept on the resident file and completed when family visit or ring.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and family/whānau are encouraged to visit at any time. The family report there are no restrictions to visiting hours.</p> <p>Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme.</p> <p>The facility is close to community facilities and residents report they are encouraged to access these independently as able.</p> <p>The service encourages the community to be a part of the resident's lives with visits from kindergartens, entertainers, RSA volunteers and from a Maori health provider.</p> <p>There is a Woodlands newsletter sent out to family and residents quarterly.</p>
<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>Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints.</p> <p>Complaints management is explained as part of the admission process for residents and family/whānau and is part of the staff orientation programme and ongoing education.</p>

		<p>Residents and family/whānau confirm that the management's open door policy makes it easy to discuss concerns at any time. The complaints register records the complaint, dates and actions taken and these are addressed to comply with right 10 of the Code. There were no outstanding complaints at the time of audit.</p> <p>Staff understand and implement the complaints process for written and verbal complaints that occur.</p> <p>There have been no complaints lodged with external authorities since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The business and care manager, clinical manager or a registered nurse discusses the Code, including the complaints process with residents and their family on admission.</p> <p>Discussions relating to the Code are also held at the resident meetings.</p> <p>Residents and family confirm their rights are being upheld by the service.</p> <p>Information regarding the Health and Disability Advocacy Service is clearly displayed in the foyer of the facility.</p> <p>The resident right to access advocacy services is identified for residents and advocacy service leaflets are available at the entrance to the service. If necessary, staff could read and explain information to residents as stated by the health care assistants and registered nurses interviewed.</p> <p>Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.</p> <p>Residents and family members are able to describe their rights and advocacy services particularly in relation to the complaints process.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has a philosophy that promotes dignity and respect and quality of life. Resident support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values with care plans completed with the resident and family member (confirmed by residents and family interviewed).</p> <p>Interventions to support these are identified and evaluated.</p> <p>Residents are addressed by their preferred name and this is documented in files reviewed.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to</p>

		<p>manage any inappropriate behaviour.</p> <p>The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which could be used for private meetings.</p> <p>Health care assistants reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families confirm the residents' privacy is respected.</p> <p>Health care assistants state they encourage the residents' independence by encouraging them to be as active as possible.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service implements the Maori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan.</p> <p>Links to local kaumatua are documented.</p> <p>Any Maori resident living at the facility has a cultural assessment completed with any preferences documented.</p> <p>Staff report that specific cultural needs are identified in the residents' care plans and this was sighted in files reviewed.</p> <p>Staff are aware of the importance of whanau in the delivery of care for the Maori residents.</p> <p>Cultural safety training is provided annually to all staff.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies each resident's personal needs from the time of admission. This is completed with the resident, family and/or their representative having input into the admission, assessment and planning processes.</p> <p>There is a culture of choice with the resident determining when cares occur, times for meals, choices in meals and choices in activities. Health care assistants are able to give examples of how choices are given to residents who had non-verbal ways of communicating. In the dementia unit, staff were observed to provide choice for residents with activities being individualised, food choices and choice to interact with others in the rest home and hospital.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff files have job descriptions, employment agreements and staff handbooks that have clear guidelines regarding professional boundaries. Families and residents report they are satisfied with the care provided. The families expressed no concerns with breaches in professional boundaries, discrimination or harassment. The staff satisfaction survey indicates that there is an increase in staff satisfaction at the service since the current business and care manager has been in the role. Residents also commented on the positive approach to care provided with this increasing over the past year. All state that they are 'very happy' with care provided.</p> <p>The orientation and employee agreement provided to staff on induction includes standards of conduct.</p> <p>Interviews with staff confirm their understanding of professional boundaries, including the boundaries of the health care assistants' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are policies and procedures to guide practice. These policies align with the health and disability services standards and are reviewed bi-annually. A quality framework supports an internal audit programme. Benchmarking occurs across all Oceania facilities.</p> <p>There is a training programme implemented. Staff described sound practice based on policies and procedures, care plans and information given to them via the registered nurse.</p> <p>There is a training programme for all staff and managers are encouraged to complete management training. There are monthly regional management and clinical meetings attended by the business and care and the clinical managers. Specialised training and related competencies are in place for the clinical staff.</p> <p>Residents and families interviewed expressed a high level of satisfaction with the care delivered.</p> <p>The general practitioner reported a high standard of care provided at the service.</p> <p>Consultation is available through the organisation's management team at head office that includes registered nurses, regional manager, clinical and quality manager and dietitian.</p> <p>Work has been completed to improve the culture of the service, a reduction in restraint and a focus on reducing falls.</p>
<p>Standard 1.1.9: Communication</p>	<p>FA</p>	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in 15 completed accident/incident forms.</p> <p>Family contact is recorded in residents' files.</p> <p>Interviews with family members confirmed they are kept informed. Family also confirmed that they are invited to the care planning meetings for their family member and could attend the resident meetings. There are two monthly meetings for family of residents in the dementia unit. This serves as a support group for family members and is an opportunity for them to hear from speakers about dementia and related topics.</p> <p>Interpreter services are available from the district health board. There are no residents requiring interpreting services.</p> <p>The information pack is available in large print and this could be read to residents.</p> <p>Staff had training around communication in 2014 and 2015.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. All were signed on the day of admission.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service provides rest home, hospital and dementia level of care under the aged care contract. The service is able to provide support for a maximum of 63 residents with 22 beds identified as rest home only, 16 as hospital only, 11 dementia beds and 14 identified as dual purpose (rest home or hospital). There was an occupancy of 48 on the day of the audit (30 residents requiring rest home level of care, 4 requiring care in the dementia unit and 14 requiring hospital level of care).</p> <p>Woodlands is part of the Oceania group with the executive management team including the chief executive, general manager, regional manager, operations manager and clinical and quality manager providing support to the service. The clinical and quality manager and the operations manager visit at least monthly and provide support to the business and care manager and the clinical manager.</p> <p>Oceania has a clear mission, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training provided annually.</p> <p>The business and care manager (business and care manager – registered nurse) is an experienced health manager and has been in this position for a year. The business and care manager is supported by a clinical manager. The BCM and clinical manager personnel files indicate that both</p>

		<p>have attended education relevant to their roles.</p> <p>Reconfiguration of Services. The service applied to HealthCERT to reduce the number of dementia beds from 17 to 11 with an increase of rest home beds from 16 to 22. The service has had approval to use these with confirmation provided at this audit that the reconfiguration is appropriate to the needs of residents requiring either rest home or dementia care.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>There is a clinical manager (registered nurse) who is the second in charge with the clinical and quality manager (registered nurse) and the regional operations manager providing support and oversight in the absence of the business and care manager. The clinical manager has extensive experience in aged care and they are confident in their ability to perform the BCM role during temporary absences. A new clinical manager is being recruited to replace the existing clinical manager with HealthCERT notified of the change. The business and care manager and the quality and clinical manager describe their role in the documented orientation and support process.</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>	FA	<p>Woodlands uses the Oceania quality and risk management framework that is documented to guide practice. The operations and business brief identifies specific areas for development and the plan is reported on through the business and care manager's business status reports to the executive team.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to say that they have read and understood.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed. There is documentation that includes collection, collation, and identification of trends and analysis of data.</p> <p>Meeting minutes evidence communication with all staff around all aspects of quality improvement and risk management. There are also two monthly resident meetings that keep residents informed of any changes and two monthly family meetings in the dementia unit. Staff report that they are kept informed of quality improvements.</p> <p>There is an annual family and resident satisfaction survey with a high level of satisfaction</p>

		<p>documented. Corrective action plans are in place when areas are identified as having a lower rate of satisfaction.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly and quarterly through the facility checks.</p> <p>The reconfiguration of beds has not required any change to the quality and risk management programme.</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>Policy identifies that the organisation requires all incidents, accident and adverse events to be reported immediately. Responsibilities are clearly identified.</p> <p>Management understood their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified. Staff state they report and record all incidents and accidents and that this information is shared at all levels of the organisation, including any follow up actions required.</p> <p>Incident and accident reporting processes are well documented and any corrective actions to be taken are shown on the forms used by the service. Families are notified of any adverse, unplanned or untoward events at times they have nominated. Management confirm that information gathered from incident and accidents is used as an opportunity to improve services where indicated. Falls management strategies are implemented for residents who have falls.</p> <p>The clinical indicator reports monthly are used to review trends and the service can also benchmark their progress against other Oceania facilities.</p> <p>The reconfiguration of beds has not required any change to the training programme.</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</p>	FA	<p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.</p> <p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies</p>

<p>of legislation.</p>		<p>for their roles. Competencies are completed annually.</p> <p>Staff undertake training and education related to their appointed roles. Education records are retained in staff files and in training records.</p> <p>Residents and families along with the resident and relatives satisfaction survey results, identify that residents' needs are met by the service. No negative comments or opportunities were voiced during interviews on the days of audit.</p> <p>All staff working in the dementia unit have completed the dementia training or are enrolled if they are newly appointed. Staff also have the opportunity to attend further training around dementia for example 'Walking in Another's Shoes' training.</p> <p>All health care assistants interviewed confirmed an understanding of strategies to manage challenging behaviour.</p> <p>The reconfiguration of beds has not required any change to the quality and risk management programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy identifies staffing levels and skill mix with these maintained to meet residents' needs. Documentation identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe and quality care.</p> <p>The business and care manager and clinical manager report that additional staff would be rostered to meet residents' needs and this was confirmed by staff interviewed.</p> <p>Rosters show that staff are replaced when on annual leave or sick leave. Staff confirm there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents interviewed stated that all their needs have been met in a timely manner.</p> <p>There is always at least one staff member rostered on to each shift with first aid qualifications.</p> <p>The business and care manager and the clinical manager are on call.</p> <p>There are appropriate levels of kitchen, cleaning, activity and maintenance staff. There has not been any requirement to change staffing levels with the reconfiguration of beds as the now rest home beds are not currently in use. Provision is made in the staffing policy to increase staffing if resident numbers increase.</p>
<p>Standard 1.2.9: Consumer</p>	<p>FA</p>	<p>Information is entered into the resident information management system in an accurate and timely</p>

<p>Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>manner. Records are securely stored. Archived records are stored onsite.</p> <p>Progress note entries are made by staff on duty at each shift. The records are legible and the name and designation of the staff member documented on records. All records pertaining to individual residents are integrated. Information of a private or personal nature is maintained in a secure manner and is not publicly accessible.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Entry and assessment processes are recorded and implemented. The service's philosophy is displayed at the facility and communicated to residents, family, relevant agencies and staff. The facility information pack is available for residents and their family and contains all relevant information.</p> <p>The residents' admission agreements reviewed evidenced resident and /or family and facility representative sign off. The admission agreement defines the scope of the service and includes all contractual requirements. The needs assessments are completed for rest home, hospital and dementia level of care. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is appropriate communication between families and other providers, that demonstrate transition, exit, discharge or transfer plans are communicated, when required.</p> <p>Review of a resident's file evidenced a planned discharge was in process. The resident was admitted for long term care for management of wounds and pain. The file evidenced short term care plan for pain management and reduction of use of controlled drugs. Wound management plans were documented and evidenced the wounds have healed. A transition to home routine plan was developed by the needs assessment team and specific goals recorded to be attained prior to discharge including support work approval of home based support package. There was evidence of a multidisciplinary involvement of the: GP; district nurses; physiotherapist; occupational therapist; medical social worker and the needs assessor/ service coordinators from Nelson DHB. Interview with the resident and family confirmed involvement in the discharge planning process and communication in respect of the support systems to be provided at home.</p>
<p>Standard 1.3.12: Medicine Management</p>	FA	<p>The medicine management system meets guidelines and current legislative requirements. The prescribed medications are delivered to the facility and checked on entry. The medication areas,</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>including controlled drug storage evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stock takes. The medication fridge temperatures were conducted and recorded.</p> <p>All staff authorised to administer medicines have current competencies. The medication rounds were observed and evidenced the staff members were knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.</p> <p>Medicine charts evidence residents' photo identification, legibility, as required (PRN) medication is identified for individual residents and correctly prescribed, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. The residents' medicine charts record all medications a resident is taking (including name, dose, frequency and route to be given). There was one resident self-administering medicines at the facility and this was conducted according to policy.</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 policies and procedures are appropriate to the service setting with a seasonal menu reviewed by a dietitian.</p> <p>In interview, the cook confirmed they were aware of the residents' individual dietary needs. The residents' dietary requirements are identified, documented and reviewed on a regular basis. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the cook.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided.</p> <p>The food temperatures are recorded as are the fridge, chiller and freezer temperatures. All decanted food is dated. Kitchen staff have completed food safety training.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau</p>	<p>FA</p>	<p>The business and care manager (BCM) stated that a process to inform residents and family, in an appropriate manner, of the reasons why the service had been declined would be implemented, if required. The residents would be declined entry if not within the scope of the service or if a bed was not available. The BCM stated there have been no declined entries to the service since their appointment.</p>

is managed by the organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The residents' needs, outcomes and goals are identified via the assessment process and recorded. The facility has processes in place to seek information from a range of sources, for example; family; GP; specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.</p> <p>The residents' files evidenced residents' discharge/transfer information from the district health board (DHB), where required were available. The facility has appropriate resources and equipment, confirmed at staff interviews. Assessments are conducted in a safe and appropriate setting including visits from the doctor. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The residents' care plans are individualised, integrated and up to date. The care plan interventions reflect the risk assessments and the level of care required. Short term care plans are developed, when required and signed off by the RN when problems are resolved. In interviews, staff reported they receive adequate information for continuity of residents' care. The residents have input into their care planning and review. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interview.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records are current. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In Interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.</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</p>	FA	<p>In interview, the diversional therapist (DT) and the activities coordinator (AC) confirmed the activities programmes meet the needs of the service group and the service has appropriate equipment. The DT and the AC plan, implement and evaluate the activities programmes. There is one activities programme for the rest home and hospital residents and one programme for residents with dementia. Along with the activities staff, the health care assistants in the dementia unit implement individual residents' activities, as recorded on the residents' 24 hour activities care plans. Interviews</p>

the service.		<p>with health care assistants confirmed this.</p> <p>Regular exercises and outings are provided for those residents able to partake. The activities programmes includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. There are current, individualised activities care plans in residents' files. The residents' activities attendance records are maintained. The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programme. Family meetings are held at the facility and family interviews confirmed attendance.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Time frames in relation to care planning evaluations are documented. The residents' files evidenced the residents' care plans were up-to-date and reviewed six monthly. There is evidence of resident, family, health care assistants, activities staff and GP input in care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <p>The residents' progress records are entered on each shift. When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans are in some of the residents' files, used when required. The family are notified of any changes in resident's condition, confirmed at family interviews.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Appropriate processes are in place to provide choices for residents in accessing or referring to other health and/or disability services. Family communication sheets confirm family involvement. An effective multidisciplinary team approach is maintained and progress notes detail relevant processes are implemented.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to</p>

<p>providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>read and are free from damage. Material safety data sheets are available throughout the facility and accessible for staff.</p> <p>Chemicals are stored securely.</p> <p>Personal protective equipment/clothing (PPE) sighted includes disposable gloves, aprons and goggles. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</p> <p>Staff interviewed confirm they can access PPE at any time and were observed wearing disposal gloves and aprons appropriately.</p> <p>The cleaner demonstrated knowledge of handling waste and chemicals. The cleaning trolleys when in use were kept beside the cleaners at all times.</p> <p>The hazard register is current with this displayed in the staff room. Staff record any new hazards on hazard forms and the register is updated as required. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</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>Documentation identifies that all processes are undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires in March 2016.</p> <p>Maintenance is undertaken by maintenance staff as required. Electrical safety testing occurs annually and all electrical equipment sighted had an approved testing tag. Clinical equipment is tested and calibrated by an approved provider at least annually.</p> <p>A planned maintenance schedule is in place with the service addressing issues before they arise.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. Regular environmental audits identify any areas requiring improvement. The dementia unit is secure with key pad access. The original doors that separated off a larger dementia unit are now open with access for residents to the wider service.</p> <p>There are external areas off the lounge and dining areas. Outdoor areas have shade. There is access to garden areas with a secure garden and paved area for residents in the dementia unit. Gardens are raised and encourage residents to continue outdoor activities.</p> <p>Residents and family members confirm that the environment is suitable to meet their needs.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>There are adequate numbers of accessible toilets/bathing facilities located in each wing. Visitor's toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members interviewed report that there are sufficient toilets and showers. This includes sufficient and accessible numbers of toilet and shower facilities in both the rest home and dementia areas.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner.</p> <p>Residents spoke positively about their rooms. Equipment was sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff and the resident.</p> <p>Rooms could be personalized with furnishings, photos and other personal adornments and the service encourages residents to make the room their own.</p> <p>There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has lounge/dining areas including areas that could be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>Residents could choose to have their meals in their room.</p> <p>The rest home beds that have been added are close to a dining/lounge area. The dementia unit has its own dining and lounge area.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe</p>	FA	<p>The service has standing operating procedures in place for cleaning. There is a dedicated secure storage area for cleaning equipment and chemicals with a locked cupboard available in the dementia unit. The cleaner states that there is training around the use of products and cleaners are reminded to keep the trolley with them at all times. Cleaning is monitored through the internal audit</p>

<p>and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>process with no issues identified in audits.</p> <p>All laundry, including residents' personal laundry, is completed at another facility. Staff interviewed confirm they always have enough linen to meet day-to-day needs.</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>	<p>FA</p>	<p>Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked monthly by an approved provider.</p> <p>Emergency supplies and equipment include food and water. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting, availability of a generator and a gas BBQ that can be used for cooking.</p> <p>The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved fire evacuation plan. A letter sighted from the New Zealand Fire Service confirms the approved evacuation scheme. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service. Emergency education and training for staff includes six monthly trial evacuations.</p> <p>Appropriate security systems are in place with patrols from an external security firm overnight. Staff and residents confirm they feel safe at all times.</p> <p>Call bells are located in all resident areas. Resident and family/whānau interviews confirm call bells are answered in an acceptable timeframe. Call bells randomly checked on the day of the audit were displayed and answered in a timely manner.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.</p> <p>Family and residents state that the building is maintained at an appropriate temperature with underfloor heating.</p>
<p>Standard 3.1: Infection control</p>	<p>FA</p>	<p>The infection control (IC) policy and procedures provide information and resources to inform staff on</p>

<p>management</p> <p>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.</p>		<p>infection prevention and control.</p> <p>The delegation of infection control matters is documented in policies, along with an infection control coordinator's (ICC) job description. The infection control coordinator is the clinical manager/ registered nurse. There is evidence of regular reports on infection related issues and these are communicated to staff and management. The IC programme is reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICC has access to relevant and current information which is appropriate to the size and complexity of the service, including but not limited to: IC manual; internet; access to experts; and education. The IC is an agenda item at the facility's meetings, evidenced during review of meeting minutes and interviews with staff.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	<p>The IC policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interviews. The IC policies and procedures are developed and reviewed regularly in consultation and input from relevant staff, and external specialists. IC policies and procedures identify links to other documentation in the facility.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control education is provided to all staff, as part of their orientation and as part of the on-going in-service education programme. In interviews, staff advised that clinical staff identify situations where IC education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted. The IC staff education is provided by the ICC, RNs and external specialists. Education sessions have evidence of staff attendance/ participation and content of the presentations. Staff are required to complete IC competencies, sighted in staff files and confirmed at staff interviews.</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>The infection control co-ordinator confirmed a surveillance programme was maintained. Surveillance data was sighted and included infection details related to files sampled. Monthly analysis was completed and reported at monthly general staff meetings.</p> <p>The infection control surveillance is appropriate to the size of the service.</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes.</p> <p>The infection control surveillance data was sampled through resident records, staff interviews, and clinical indicators and collated infection reports. This information confirmed the surveillance programme is appropriate and fully implemented. The infection control data is communicated to staff at facility's meetings. Infection logs are maintained for infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short term care plan.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RN's, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interview, the ICC confirmed no outbreak occurred at the facility since last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enabler is congruent with the definition in the Standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There were no residents at the facility using enablers and two residents using restraint. Residents who use restraints have risk management plans in place. The restraints are documented in their care plans.</p> <p>The approval process for enabler use will be activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.</p> <p>In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training was provided. The staff restraint competencies are current.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The facility has a process for determining approval of all types of restraints used. The restraint coordinator completes a restraint assessment which is then discussed with the GP prior to commencement of any restraints. The restraint approval group is defined in the restraint minimisation and safety policies and procedures.</p> <p>The forms of restraint are approved by the Oceania head office and lists: indications for use; associated risks with restraint; safe use: and safety precautions and minimum observation / monitoring requirements.</p> <p>The restraint is documented in the care plans of residents. Health care assistants are responsible for monitoring and completing restraint forms when the restraint is in use. Evidence of ongoing education regarding restraint and challenging behaviours is evident.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Restraint assessments are conducted by RNs and the CM. Restraint assessments include: identification of restraint related risks; underlying causes for behaviour that requires restraint; existing advanced directives; past history of restraint use; history of abuse and or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes; and possible alternatives to restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Strategies are implemented prior to use of restraint to prevent the resident from incurring injury for example: the use of low beds; mattresses and sensor mats. Restraint consents are signed by appropriate staff and family/ resident.</p> <p>Restraints are recorded in the care plans and reviewed along with the care plan reviews. The restraint register is up to date and records all necessary information.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Each episode of restraint is evaluated. Restraint reviews include: the effectiveness of restraint in use; restraint related injuries; and whether the restraint is still required.</p> <p>The resident (if able) and the family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Oceania National Restraint Authority Group meeting was conducted in February 2015. The meeting minutes record: the approval of types of restraint; extent of restraint use; trends identified across Oceania Health care facilities; progress in reducing restraint nationally; adverse outcomes from restraint interventions; staff compliance with restraint programme policies and protocols; and restraint practices and staff knowledge and competency in relation to restraint..</p> <p>There is evidence of monitoring and quality review of use of restraints at the facility.</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)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	Residents' files evidenced completion of initial risk assessments and initial care plans and review of risk assessments and care plans are conducted within the required timeframes. Residents' care plans are not consistently completed within the required timeframe of three weeks from admission to the facility. Three of twelve residents' files evidenced the care plans were completed past the three week period.	Residents' long term care plans are not consistently conducted within the required timeframes.	<p>Provide evidence residents' long term care plans are conducted within the required timeframes.</p> <p>180 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.