

Benhaven Care Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Benhaven Care Limited
Premises audited:	Benhaven Rest Home
Services audited:	Residential disability services - Intellectual; Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 4 June 2015 End date: 5 June 2015
Proposed changes to current services (if any):	.
Total beds occupied across all premises included in the audit on the first day of the audit:	16

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

Benhaven provides care and support for up to 19 residents at rest home level care and residential disability services (intellectual and physical). On the days of audit there were 16 residents.

The owner of Benhaven is actively involved in the operational management of the service, with a registered nurse managing clinical services. The service continues to implement a quality and risk management system.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and a general practitioner.

Ten of eleven shortfalls from the previous certification audit have been addressed. These relate to informed consent, cover for temporary absence of the registered nurse/manager, care planning, delivery and evaluation, activity plans, medication management, fridge temperature monitoring, frequency of fire drills and education for the infection control coordinator. Further improvements continue to be required around informing family following incidents.

This audit identified that improvements are required around clinical documentation following falls, quality process documentation and infection control surveillance.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Benhaven provides care in a way that focuses on the individual resident. Family are informed when resident health status changes. There is a documented process for making complaints and residents, family and staff interviewed are able to discuss the complaints process.

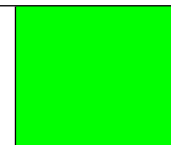
Organisational management

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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Benhaven continues to implement a quality and risk management system and staff meetings are held. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes discussion about incidents, complaints, and infections. There are implemented human resources policies including recruitment, selection, orientation and staff training and development. Sufficient staff are rostered on to meet the needs of residents.

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.

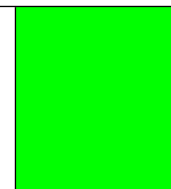


Standards applicable to this service fully attained.

Assessments, care plans and evaluations are completed by the registered nurse using the InterRAI process. Care plans are individualised and evaluated six monthly. The resident/family/whanau confirms they are involved in the care plan process and review. Long term care plans are in place. Short term care plans are used for short term health issues. There is activities programme across five days a week. There is a medication management system in place. Meals are prepared on-site and individual and special dietary needs are catered for.

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.

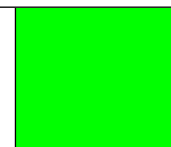


Standards applicable to this service fully attained.

There is a current building warrant of fitness.

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.

The restraint policy and procedure has a clear definition of restraint and enablers. There are no residents requiring restraint and none utilising enablers. Staff receive education related to restraint minimisation during orientation and as part of the education programme.

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.		Some standards applicable to this service partially attained and of low risk.
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Infections are reported monthly. Infections and internal audit outcomes are discussed as part of the staff meetings. Information is available to staff.

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	18	0	4	0	0	0
Criteria	0	43	0	5	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 1.1.10: 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>Five resident files were reviewed, all had documented informed consent and advanced directives in the resident files. Advised by staff that family involvement occurs with the consent of the resident. Resident admission agreements were signed. This is an improvement from the previous audit.</p> <p>Discussion with four residents, two of which were under 65, all agreed that the staff gave good explanations and always asked permission prior to entering resident rooms, this was also witnessed on the days of audit.</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>A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Two relatives and four residents are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. No external complaints were received in 2014. The service documents all issues raised by resident and these are documented as followed up and resolved appropriately.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	PA Low	<p>Benhaven has policies and procedures in place around open disclosure and two family members interviewed stated they are informed of changes in health status</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>and incidents/accidents. Four residents interviewed felt very informed. Resident meetings are documented as taking place regularly and this included encouraging residents to provide feedback on services provided. Annual resident/family satisfaction survey May 2014 includes documented discussion with relatives around issues raised.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family have difficulty with written or spoken English the interpreter services are made available. Previous certification audit finding in 1.2.4.3 relating to communication with families following incidents remains.</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>Benhaven is owned by a non-clinical director and is managed by a registered nurse. The registered nurse (RN) manager works 40 hours a week and is on call as needed. She has been in the role for a year. A relief registered nurse is available in the temporary absence of the registered nurse manager and to assist with on call.</p> <p>The service provides care and support for up to 19 residents for rest home level care and residential disability services – intellectual and physical. On the days of the audit there were 16 residents in total (11 residents at rest home level and 5 residents receiving residential disability services including one respite).</p> <p>The owner is actively involved in the operational management of the service and oversees the administration of the service, with the RN managing clinical services. Weekly meetings are documented and daily feedback and communication takes place.</p> <p>There is a business plan 2015 and separate quality process. Benhaven continues to monitor quality objectives through an implemented audit schedule and trending of incident reporting with exceptions (link #1.2.3.1).</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>	<p>FA</p>	<p>The registered nurse/manager continues to work fulltime and to provide on call services with the backup of the owner (non-clinical) who lives on site. Since the previous audit the service has employed a registered nurse who is able to cover temporary absences, and assist with on call. This is an improvement on the previous audit.</p> <p>D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies,</p>

		QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.
<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>	PA Low	<p>Benhaven continues to implement an appropriate quality and risk process. There is a system of monthly audits, and audits are documented as taking place according to the audit schedule. Monthly review of incident and accidents, individual resident infections, monthly complaints and restraint (if needed) are documented in staff/quality meetings monthly. The registered nurse manager advised that staff/quality meetings are used as a forum to collect information for the internal audit process. Four caregivers interviewed agreed that the meetings are used to discuss issues and problems.</p> <p>Corrective actions are documented for areas of non-compliance.</p> <p>The service has a business risk assessment and management plan and this includes a quality plan. The service has in place a range of policies and procedures to support service delivery. These policies are/have been reviewed regularly to ensure they are in line with current practice, this includes the InterRAI process for resident assessment and support. There is a document control system. Documents no longer relevant to the service are removed and archived.</p> <p>Discussion with four caregivers and the cook identified an understanding of the policies and procedures. There are implemented health and safety policies that include hazard identification.</p> <p>There is a maintenance schedule implemented and issues are managed promptly as these arise. A review of the documentation indicates that maintenance issues and hazards are resolved promptly.</p> <p>Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.</p> <p>There are infection control policies and procedure, a restraint policy and health and safety policies and procedures.</p> <p>D19.2g: Falls prevention strategies are in place that include the analysis of falls incidents, sensor mats for relevant residents and the identification of interventions on a case by case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	PA Low	<p>Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant</p>

<p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>authorities in relation to essential notifications. A sample of resident related incident reports April and May 2015 were reviewed. Clinical review following an incident or accident is provided by the registered nurse. Previous certification audit finding relating to family communication is addressed in 1.1.9.1. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p>
<p>Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to guide practice. An orientation programme is in place. Caregivers are medication competent. The caregivers could describe the orientation process. There is a very low turnover of caregivers and a new staff member is always rostered on with another staff member.</p> <p>On review of the five staff files, relevant documents were evidenced and performance appraisals were up to date and completed annually. Discussions with caregivers and a review of the documentation indicates there is regular in-service provided.</p> <p>D17.7d: There are implemented competencies for staff related to medication with all relevant caregivers. The registered nurse/manager and the relief registered nurse both have a current practicing certificate.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate, one full and one half shift for the morning and afternoon shift and one on night shift (2300-0700). The registered nurse/manager works full time five days per week. The activities coordinator works a total of 15 hours per week, which is split over mornings and afternoons. The GP interviewed confirmed that staffing is appropriate to meet the needs of residents. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times.</p>
<p>Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service uses individualised medication packs which are checked in on delivery. Sachet packs are used for long term residents and blister packs for short term residents. A competent caregiver was observed administering medications correctly. Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were evident on all 14 medication charts reviewed. An annual medication administration competency</p>

		<p>was completed for all staff administering medications and medication training had been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. There were currently no residents who self-administered medications. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed.</p> <p>Previous shortfalls around three-monthly review, indications for use with needed medications, transcribing, and the process and checking on medications on administration have all been rectified.</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>	FA	<p>All meals at Benhaven are prepared and cooked on site in the large kitchen. Observation of meals in the dining room evidences that this is a calm environment, all residents are provided with hot, well prepared meals. Four residents interviewed agreed that the meals are lovely and they have plenty to eat. Staff were observed assisting residents with their lunch time meals and drinks. Diets are modified as required. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Family members interviewed indicated satisfaction with the food service.</p> <p>Fridge temperatures in the kitchen have been recorded weekly and are within acceptable limits. This is an improvement on the previous audit.</p> <p>D19.2: Staff working in the kitchen have food handling certificates and receive on-going training.</p>
<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>Benhaven has adopted the InterRAI assessment tool for conducting all assessments and these were evidenced on the four long term resident files reviewed (The fifth was a respite resident). All four long term resident files had care plans that addressed the assessed needs from the InterRAI and also included other resident needs as noted by the RN informal assessment and following discussion with family/resident. The previous audit noted that all assessments had not been in place on admission and at six monthly intervals. The introduction of InterRAI has corrected this. All five resident files documented a nutritional assessment that included special diets and resident likes/dislikes. There were no residents with weight loss at the time of audit. Pain assessments were documented for all residents with PRN analgesia. The service has</p>

		addressed all findings around nutrition, assessment and pain since the previous audit.
<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>Resident files reviewed included all required documentation. The long term care plans recorded the resident's problem/need, objectives, interventions and evaluation for identified issues. The service has a specific acute health needs care plan that included short term cares. Resident files reviewed identified that family (where possible) were involved in the care plan development and on-going care needs of the resident.</p> <p>The previous audit found that one care plan had not been reviewed within time frames and one care plan did not have an activities plan. This audit evidenced timely care plan reviews for four long term care plans (the fifth was a short term resident), and all five residents had an activities plan in place.</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>Five care plans reviewed; two rest home, two under 65 contract and one respite. Since the previous audit all care plans have been reviewed and residents re-assessed using the InterRAI tool. Care plans are current and interventions reflect the assessments conducted and the identified requirements of the residents. This is an improvement on the previous audit.</p> <p>Interviews with four caregivers, four residents and two family members confirmed involvement all staff residents and families in the care planning process.</p> <p>Dressing supplies were available. Contenance products were available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. The service has no residents with a wound at present.</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>	FA	<p>Activities are provided Monday to Friday. The activities person has commenced the diversional therapy course, and she has been in the post at Benhaven for a year. Each individual resident has an activity plan that has been evaluated and updated six monthly.</p> <p>The activities person described how the activities are adapted to the range of residents so that there is always an activity to suit the different needs such as older person and under 65s. There are community visits and some residents continue to attend clubs and maintain social links with community groups.</p> <p>Resident meetings reviewed all discuss the activities programme and the activities</p>

		<p>person described how changes are made as a result of feedback.</p> <p>Interviews with four residents and two families praised the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The InterRAI process has been introduced since the previous audit. All five care plans reviewed documented an evaluation using InterRAI. Care plans had been updated with changes to care both with six monthly evaluations and as needed. Short term care plans were in use. Care plans are evaluated within the required time frames. This is an improvement on the previous audit.</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>	FA	<p>The service displays a current building warrant of fitness which expires on 28th September 2015.</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>Fire drills have been documented as occurring six monthly since the previous audit and the training planning documented they are booked six monthly for 2015. The most recent is dated 30th April 2015. The service has addressed and monitored this previous finding.</p> <p>Emergency plans include a disaster plan. There is sufficient supplies of bottled water and food stored in the event of an emergency. The facility is part of the Upper Hutt Emergency Preparedness Network (Ready net).</p> <p>D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.</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 policy states that the facility is committed to the on-going education of staff and residents. Infection control training is documented and a record of attendance is maintained – last provided May 2015 (five attended). Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. The registered nurse/manager is the infection control coordinator, she has undertaken IC training via an on-line training session. This is an improvement from the previous audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p>	PA Low	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is</p>

<p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>the designated infection control nurse. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Infections are discussed at staff meetings on an individual basis.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has no residents with restraints or enablers. There is a documented policy and procedure in place which aligns with the standard. Enabler use is voluntary. Staff report that restraint and enabler use has been discussed at staff meetings, should this be required.</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)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Previous certification audit identified that communication with families was not routinely conducted or documented following incidents and accidents (previous finding 1.2.4.3). A sample of resident related incident reports for April and May 2015 were reviewed. The reporting to family following an incident remains a finding. Families interviewed advised that the service kept them informed of the resident's health status and if changes or incidents had occurred.</p>	<p>Following a review of eight resident related incident forms, four of eight forms did not document if the family had been informed following an incident. These incidents related to falls and wandering. Advised by staff that not all residents had family for notification of incidents and accidents.</p>	<p>Ensure that communication with family (where appropriate) is clearly documented following an incident or accident.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results</p>	PA Low	<p>Quality activities are conducted at Benhaven and include internal audit, meetings, surveys and feedback from staff, residents and families. The documentation of discussion around</p>	<p>Staff advise on interview that staff meetings are used to assist with the audit process, however, meeting minutes reviewed do not evidence that discussions of the internal audit</p>	<p>Ensure that meeting minutes document the discussion of audit outcomes and any</p>

communicated to service providers and, where appropriate, consumers.		outcomes of audits and the completion of action plans post audit where audits identify problems is an area for improvement	outcomes have been held.	actions 90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	There is a documented quality and risk system and process in place. Staff interviews confirm that there is discussion of both internal audits and any actions needed to rectify shortfalls identified. Corrective actions are developed with exceptions.	A review of the internal audits evidences that corrective action plans are not always completed. The January cleaning audit and February continence audit are examples.	<p>Ensure that action plans are documented and followed up for internal audits with identified shortfalls.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	Incident and accident data is collected for falls, skin tears, challenging behaviours, wandering, and medication errors. A sample of eight incident reports for April and May 2015 evidenced that forms were completed by the person attending to the resident with clinical follow up provided by the registered nurse. One incident form reviewed and associated resident file did not record all clinical action taken.	One incident form reviewed recorded that the resident had a suspected head injury. Medical assistance had been provided and it is documented that the registered nurse manager had asked for additional monitoring. The nurse manager phoned to check the resident's condition overnight, however, neurological observations were not documented.	<p>Ensure neurological observations are undertaken and recorded following a suspected head injury.</p> <p>60 days</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	PA Low	Monthly staff meetings document that each resident with an infection is discussed. Resident care plans document that infections are addressed.	The surveillance and monitoring of all infections is not entered on to a monthly facility infection summary. The individual infections results are not gathered, collated or analysed for trends and opportunities for improving infection rates.	<p>Ensure that a monthly summary of infections is maintained.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.