Oceania Care Company Limited - Palm Grove Lifestyle Care & Village

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 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:	Palm Grove Lifestyle Care & Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 October 2015 End date: 2 October 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 68

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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

This surveillance audit was undertaken to monitor compliance with the Health and Disability Services Standards and the District Health Board contract. The facility is operated by Oceania Care Company Limited.

Palm Grove Lifestyle Care & Village can provide care for up to 85 residents and on the days of this audit there were 68 residents. The audit process included a review of policies and procedures, review of a sample of resident and staff files, observations, interviews with residents, family, management and staff.

Four areas were identified as requiring improvement during this audit. The improvements required relate to documentation of records, timeframes for services, care plans and medication management. Residents and family members interviewed were positive about the care provided. It is noted that there were no requirements for improvement identified at the previous certification audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights information (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, was accessible. This information is brought to the attention of residents' and their families on admission to the facility. Residents and family members interviewed confirmed their rights were met, staff were respectful of their needs and communication was appropriate.

The service received a complaint addressed to the Health and Disability Commissioner relating to the care of a resident. This complaint is still open and there was also a Coroner's investigation into the death of a resident which was closed as there was no need for further investigation.

Residents and family interviewed confirmed consent forms are provided. Residents and family also advised that time is provided if any discussions and explanation are required. The business and care manager is currently responsible for management of complaints.

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.

Oceania Care Company Limited is the governing body and is responsible for the service provided at the facility. The business and care manager was appointed in December 2013 and is appropriately qualified and experienced. The clinical manager is responsible for oversight of clinical care and has been with the service for the last eight months. Registered nurse cover is provided 24 hours a day.

Quality improvement data is collected, collated, analysed and reported. The internal audit programme records planned internal audits. Corrective action plans are developed to address areas identified as requiring improvement. Risks are identified and the

hazard register is up to date. Adverse events are documented on accident and incident forms and areas requiring improvement are identified. There are policies and procedures relating to human resources management processes. Staff records reviewed provided evidence human resources processes have been followed. Staff education records confirmed in-service education is provided. The validation of current annual practising certificates for health professionals who require them to practice occurs.

A documented rationale for determining staffing levels and skill mix was reviewed. The clinical manager and the two charge nurses take turns in the management of the after-hours calls. Care staff, residents and family reported there is adequate staff available.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into assessment, care planning, review of care and access to a typical range of life experiences and choices.

Residents' long term care plans record detailed interventions and these are reviewed six monthly. Where resident's progress is different from expected, the service responds by initiating changes to the long term 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 confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Medication areas, including controlled drug storage evidence an appropriate and secure medicine dispensing system. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. Residents self-administering medicines do 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 and on site staff that provide the food service. The kitchen staff have completed food safety training. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.

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.

An appropriate call bell system is available and security systems are in place. Chemicals, linen and equipment are safely stored. The service has a current building warrant of fitness. The service uses a preventative and reactive maintenance programme to ensure a safe and appropriate environment.

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.

Restraint minimisation policy and 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. Residents using restraint and enablers do so according to the standard.

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.

The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided. Surveillance of infections is occurring according to the infection control programme and policies and procedures. Identified infections are recorded, collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance. Staff are familiar with infection control measures at the facility.

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	13	0	1	3	0	0
Criteria	0	41	0	1	3	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The business and care manager is responsible for complaints. The service has appropriate systems in place to manage the complaints processes. The service records complaints, the investigation of complaints, the resolutions including acknowledgement of receiving the complaint and a closing letter addressed to the complainant with a closing-out date and sign-off. Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. The complaint process is readily accessible and displayed, and the complaints register was up-to-date. The business and care manager advised there have been no complaints to the district health board (DHB), Accident Compensation Corporation (ACC), or HealthCERT since the previous audit at this facility. There was one complaint to the Health and Disability Commissioner, which the service is in the process of resolving. Sighted communication, corrective actions records and reports to their support office. There has also been a coroner's case, which was closed, as sighted in the letter from the coroner dated 22 September 2015. Residents and family interviewed confirmed having an understanding and awareness of the complaints processes. Resident meetings are held monthly and residents are able to raise any issues they have during these meetings.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. The residents' files reviewed provided evidence that communication with family members was being documented in residents' records. There was evidence of communication with the GP and family following adverse events. The business and care manager advised access to interpreter services is available via the district health board if required. They also advised there were no residents who required interpreter services. Residents interviewed confirmed that they are aware of the staff who are responsible for their care and staff communicate well with them. Admission agreements were reviewed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Oceania Care Company Limited's vision, values, mission statement and philosophy are displayed at the entrance to the facility. The organisation has systems in place recording the scope, direction and goals of the services. The business and care manager and the clinical manager provide monthly reports to the support office relating to governance through the Oceania intranet. Governance reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators, as sighted. The business and care manager has been in this position since December 2013 and is supported in the role by a clinical manager (CM)/registered nurse (RN), the clinical and quality manager and the regional operations manager. The CM/RN started in this role in February 2015. Since the last audit the service has had one other clinical manager prior to the appointment of the current CM. The CM is employed in a full time position to work with the business and care manager and has responsibility for the management of compliance with all clinical matters. The CM worked as the charge nurse in the hospital of this service, prior to taking the role as the CM.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	A quality improvement plan with quality objectives was reviewed. Also reviewed was a quality and risk management plan. Along with the business plan, these are used to guide the quality programme and include goals and objectives. Completed internal audits for 2015 were reviewed. Family, resident and staff satisfaction surveys are completed as part of the audit programme and collated results for both surveys were reviewed. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures. Integrated quality

		improvement, health and safety, resident and clinical meetings are held monthly. Meeting minutes reviewed provided evidence of reporting//feedback on completion of internal audits and various clinical indicators. Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed, evaluated and reported. There was evidence this information is being reported to staff via weekly senior staff meetings, monthly staff meetings and clinical meetings and bi-monthly health care assistant meetings. Quality improvement data reviewed, including internal audits and meeting minutes provided evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed. Relevant standards are identified and included in the policies and procedures manuals. Policies/procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and a document control policy. Staff confirmed during interviews that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for service delivery.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff were documenting adverse, unplanned or untoward events on an accident/incident form and families are informed. Accident and incident forms are reviewed and signed off by the clinical manager and business and care manager. Corrective action plans address areas requiring improvement and were documented. There is an open disclosure policy. Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions and policies and procedures. Policy and procedures comply with essential notification reporting for example; health and safety, human resources, infection control.
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.	FA	Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position are documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checking, criminal vetting, completed orientations and competency assessments. Copies of annual practising certificates were reviewed for all staff that require them to practice and are current. The clinical manager is responsible for the in-service education programme. Competency assessment questionnaires are available and completed competencies were reviewed. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.

		An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed an orientation, including competency assessments.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided 24 hours a day. On call after hours RN support and advice is provided by the clinical manager. Care staff interviewed reported there is adequate staff available and that they are able to get through their work. There is at least one staff member with a current first aid certificate on each shift. Residents and family interviewed reported staff provide them with adequate care.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	Residents' files are maintained securely. Computers are password protected and can only be accessed by designated staff. Archived records are kept securely and are easily retrievable. All components of residents' records include the resident's unique identifier. The clinical records are organised and integrated, including information such as medical notes, assessment information and reports from other health professionals. Resident progress notes are completed every shift, detailing resident's response to service provision and progress towards identified goals. There was evidence in the files reviewed of the use of: correction fluid; pencil use; designation not always recorded and some resident information was illegible.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication areas, including controlled drug storage, evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug registers are maintained and evidence weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded. All staff, authorised to administer medicines, have current competencies. Registered nurses, enrolled nurses and care staff interviewed were able to describe their role in regard to medicine administration. The medication round observed evidenced the staff member was 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.

		Medicine charts reviewed require the as required medication (PRN) to be charted correctly. Residents who wish to self-administer medicines are appropriately assessed as being competent to self administer medications and supported to do so.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service policies and procedures are appropriate to the service setting with seasonal menus reviewed by a dietitian. A dietary assessment is undertaken for each resident on admission to the facility. A resident's dietary profile is developed on admission and reviewed six monthly or when a resident's condition alters. There are current residents' dietary profiles in residents' files and copies in the kitchen. The kitchen staff are informed if resident's dietary requirements change. Interviews with kitchen staff confirm their awareness of the residents' dietary requirements. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Residents who require special eating aids are provided for to promote independence. The residents' files demonstrate monthly monitoring of individual resident's weight. Supplements are provided to residents with identified weight loss. In interviews, residents stated they are satisfied with the food service, reported their individual preferences are met and adequate food and fluids are provided. The residents' meeting minutes' evidence feedback about the food service is positive. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	The residents' long term care plans evidence interventions based on assessed needs and desired outcomes or goals of the residents. In interviews, residents and their family confirm 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 confirm they are familiar with the current interventions of the resident they care for and that they have all the equipment referred to in care plans necessary to provide care. When a resident's condition alters, the registered nurse initiates a review and, if required, a GP consultation or referral to the appropriate health professional is actioned. Dressing supplies and continence products are available and treatment rooms are stocked for use. Short term care plans are recorded, however, the interventions recorded for the short term problem do not consistently document all the interventions required to manage the short term problem.
Standard 1.3.7: Planned	FA	Interviews with the diversional therapist (DT) and the activities coordinator confirm activities are provided

Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		from Monday to Saturday each week. The activities staff are responsible for planning, implementing and evaluating the activities programme. The activities programme records activities relating to residents' preferences, ordinary patterns of life, group activities, exercises, outings and community activities. The activities programme is displayed around the facility. Residents are assessed for appropriate recreational activity and social requirements. There are activities assessments and 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 programmes. Residents' and family interviews confirm satisfaction with the activities programmes.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Time frames in relation to care planning evaluations are documented. The residents' care plans are 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 confirm their participation in care plan evaluations and multidisciplinary reviews. 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 and used when required (refer to criterion 1.3.6.1). The family are notified of any changes in resident's condition ,as confirmed at family interviews. There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The maintenance person works 37.5 hours per week, from Monday to Friday. They advised that external contractors are used for plumbing, electrical and other specialist areas. During interview the maintenance person confirmed there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Calibration reports for medical equipment were reviewed along with current electrical safety tags on electrical items. Documentation and observations evidenced a current Building Warrant of Fitness is displayed that expires 1 June 2016. Observations of the facility provided evidence of safe storage of medical equipment. Corridors are wide enough to allow residents to safely pass each other; safety rails are secure and are appropriately located. Multiple external areas are available for residents and these are maintained to an adequate standard and are appropriate to the resident group. Residents are protected from risks associated with being outside,

		including provision of adequate and appropriate seating and shade and ensuring a safe area is available for recreation or evacuation purposes. Residents confirmed they know the processes to follow if any repairs/maintenance is required and that requests are appropriately actioned. Care staff confirmed they have access to appropriate equipment, equipment is checked before use and they are competent to use the equipment.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control nurse is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at facility's meetings and to Oceania support office. 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. Infection logs are maintained for infection events. Residents' files evidence the residents' who are diagnosed with an infection have short term care plans documented (refer to criterion 1.3.6.1). In interviews, staff report they are made aware of any infections of individual residents by way of feedback from RNs, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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 documented in policies and procedures. The residents using enablers and restraint do so according to policy. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews. In interviews with staff and in staff files there is evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training is provided. Staff restraint competencies are current.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	There was use of correction fluid in two of the nine files reviewed. Pencil use is evident in kitchen records. Some residents’ records, such as wound care plans for rest home residents are illegible. Designation of a RN is not always recorded on records sighted.	There was evidence of use of correction fluid and pencil use, illegibility of some records and staff designation not always recorded.	Provide evidence correction fluid and pencil use is discontinued, staff designation is recorded and records are legible. 90 days
Criterion 1.3.12.1	PA	Medicine charts evidence residents' photo identification, legibility, three monthly medicine reviews are conducted and	As required medications	Provide evidence the

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	Moderate	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). Thirteen of the twenty medicine charts evidence the 'as required medications' (PRN) do not record specific target symptoms and dose range.	(PRN) are not consistently prescribed correctly.	PRN medications are correctly prescribed. 90 days
Criterion 1.3.3.3 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.	PA Moderate	Four of four hospital residents' files evidence the service delivery timeframes are adhered to. Four of the five rest home residents' files evidence the timeframes relating to completion of: risk assessments; initial care plans; long term care plans; GP initial assessments; wound care plans and completion of GP exceptions are not consistently completed.	Rest home residents' files evidence service delivery timeframes are not consistently adhered to.	Provide evidence timeframes are adhered to. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Nine residents files were reviewed, five rest home and four hospital. Of the five rest home files, four were identified as requiring short term care plans for short term problems. Three of the four rest home short term care plans evidence the short term care plans do not record all the required interventions for the short term problems identified.	Short term care plans in the rest home residents' files do not consistently record all the required interventions.	Provide evidence all short term care plans record the required intervention for the short term problem. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.