

Wyndham and Districts Community Rest Home Incorporated - Wyndham and District Community Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Wyndham and Districts Community Rest Home Incorporated
Premises audited:	Wyndham and Districts Community Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 September 2016 End date: 22 September 2016
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:	17



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

Wyndham and Districts Community Rest Home provides rest home level care for up to 23 residents. There were 17 residents residing at the facility on audit days. The residents and families spoke positively about the care provided.

This surveillance audit was conducted against the sub-set of the Health and Disability Service Standards and the service's contract with the district health board. The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

There were 16 areas identified as requiring improvement at the last certification audit. Following this surveillance audit 13 areas requiring improvement have been identified as met and three areas remain open.

There is one new area requiring improvement relating to implementation of service provision timeframes.

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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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and the complaints process are accessible. Residents and family members confirmed their rights are being met, staff are respectful of their needs and communication is appropriate.

Residents were observed being treated in a professional and respectful manner. The nurse manager is responsible for the management of complaints and a complaints register is maintained.

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 medium or high risk and/or unattained and of low risk.
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Wyndham and Districts Community Rest Home Incorporated is the governing body and is responsible for the services provided at this facility. Systems are in place for monitoring the services provided including regular monthly reporting by the nurse manager to

the governing body. The nurse manager is responsible for overall management of the facility, including oversight of the clinical services.

There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff meetings are held and there is reporting on various clinical indicators, quality and risk issues and discussion of any trends identified.

There are implemented policies and procedures on human resource management. An in-service education programme is provided for staff. All new staff are provided with an orientation programme that covers all areas of service provision.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. Registered nurses are available after hours.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity. 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 information confirmed the service delivery process. Where progress is different from expected, the service responds by initiating the required changes.

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. Staff responsible for medicine management complete the required competencies. There is a process for the management of self-administration of medicines.

Food, fluid, and nutritional needs are provided in line with recognised nutritional guidelines and additional requirements/modified needs are met. All food is prepared on site and kitchen staff have completed the required 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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There is a current building warrant of fitness. There have been no building modification since the last audit. A preventative and reactive maintenance programme is in place. Fixtures and fittings are made of accepted materials for this environment. Resident rooms are of an appropriate size.

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 service has documented policies and procedures for restraint minimisation and safe practice. Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The restraint coordinator confirmed that enabler use is voluntary. There were no residents using enablers and one resident using restraint on audit days.

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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Surveillance of infections is occurring as required. Data on the nature and frequency of identified infections is collated and analysed. The results of surveillance are reported through all levels of the organisation.

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	2	2	0	0
Criteria	0	40	0	2	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and procedure, complaints flow chart and the complaints form comply with the Right 10 of the Code. This was an area requiring improvement at last certification audit and is now fully compliant. Systems are in place that ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes.</p> <p>The nurse manager is responsible for complaint management. A complaints register is maintained that included two complaints in 2015 and one complaint in 2016 and these were managed appropriately. The complaints register is up to date and includes all complaints lodged, dates and actions taken. This was an area requiring improvement at last certification audit and is now fully compliant.</p> <p>Review of meeting minutes provided evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via the staff meetings.</p> <p>There have been no investigations by the Ministry of Health, Health and Disability Commissioner, DHB, police, Coroner, or Accident Compensation Corporation (ACC) since the previous audit.</p>
<p>Standard 1.1.9: Communication</p>	PA Low	<p>There is a documented open disclosure policy. The practise of open disclosure is communicated to staff at orientation and at staff in-service education. This was last conducted in January 2016. Interpreter services are available from the district health board. There were no residents requiring interpreting services at the facility on</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>audit days.</p> <p>The area identified as requiring improvement at the certification audit relating to family notification of adverse events remains open.</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>Wyndham and Districts Community Rest Home Incorporated is the governing body and is responsible for the services provided at Wyndham Rest Home. The business plan and a quality and risk management plan includes goals. The service philosophy is available to staff, residents and their family / representative or other services involved in referring residents to the service.</p> <p>The nurse manager (NM), who is a registered nurse, is responsible for the overall management of the facility, including oversight of the clinical care provided. The NM is supported by a casual registered nurse (RN), a part time enrolled nurse (EN) and on call registered nurses who share the on call with the NM and the RN. The NM provides monthly reports to the board.</p> <p>The NM was appointed to their current position in March 2015. The nurse manager's past professional experience has been in the district health board (DHB) and private surgical hospital and community.</p> <p>Wyndham Rest Home is a 23 rest home level facility. On the first day of audit there were 17 residents at the facility. One resident is assessed as requiring hospital level care and Ministry of Health dispensation was sighted for this resident. The service provider has contracts with the district health board to provide aged related residential care (rest home) and residential respite services and hospital services for one resident.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The business plan and the quality and risk management plan are used to guide the quality programme and include goals and objectives. The risk management plan includes: health and safety risks; as well as risks associated with human resource management; legislative compliance; contractual risks and clinical risks. A health and safety manual is available and includes relevant policies and procedures.</p> <p>Monthly staff meetings are held with meeting minutes available for those staff that were unable to attend. Staff meeting minutes provide evidence of reporting / feedback on completion of internal audits and various clinical indicators. Staff interviewed reported they are kept informed of quality and risk management issues.</p> <p>Policies and procedures are documented and available to staff. The assessment and care planning policy references the interRAI assessment tool and processes relating to interRAI assessments. There is also a documented interRAI policy. This was a requirement for improvement at the certification audit and this part of the non- conformance has been attained. The updating of policies and procedures identified at last certification audit remains open.</p>

		<p>Internal audits are completed according to the audit schedule. When areas of improvements are identified, they are recorded and corrective action plans are developed, implemented, monitored and evaluated to address shortfalls. The corrective action plans are signed off when completed. Audit findings are discussed at facility's meetings. This was an area requiring improvement and has been met.</p> <p>Resident /relative satisfaction audit was conducted in 2016 and the results of the satisfaction survey have been collated and communicated to all concerned. Quality improvement data is collated, analysed and evaluated to identify trends and communicated to all concerned. This was a requirement for improvement at the certification audit and has now been closed.</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>	<p>PA Moderate</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. The registered nurse (RN) is advised of adverse events. Interviews with staff confirmed that the on-call RN visits the facility and assesses the resident following an adverse event when there is no RN on duty, if this is required. Corrective action plans to address areas requiring improvement are documented on accident/incident forms sighted.</p> <p>The previous improvement relating to essential notifications has been addressed. This related to the one resident requiring a hospital level of care at the facility. The required dispensation has been obtained from HealthCERT.</p> <p>One area identified as requiring improvement at last certification audit relating to observations of residents following adverse events remains open.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management processes are documented and implemented. The previous improvement regarding evidence in staff files has been met.</p> <p>Copies of current annual practising certificates were reviewed for all staff that require them to practice.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The NM advised that staff are orientated for two shifts at the beginning of their orientation. Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed orientation, including competency assessments (as appropriate). There are specific orientation programmes for each position within the facility, including staff orientation signing sheets and demonstrated competencies are signed off by the new staff member and the RN or the NM.</p> <p>The previous improvement regarding orientation for the nurse manager position has been addressed. The board has supported the NM in education and training relevant to this position.</p>

		<p>There is evidence of monthly staff education topics being provided at the facility. Staff education/ training attendance records reviewed evidence staff are attending in service education on regular basis. The NM has conducted relevant education relating to management of an aged care facility. Care staff have commenced/ completed the required education relating to the care of older people as stated in the ARC (Age-related Residential Care contract). There is a training action plan for staff to complete the New Zealand Qualifications Authority approved aged care education modules. Interview with the nurse manager confirmed this programme is implemented. This requirement for improvement has been met.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided five days a week (Monday to Friday) during the morning shifts. On call after hours registered nurse support and advice is shared between the nurse manager and the registered nurses. The minimum amount of staff on duty is on night shift and consists of one caregiver. The rosters sighted confirmed that replacement cover was provided in the event of staff absence.</p> <p>Care staff interviewed reported there is adequate staff available and that they are able to get through their work. All care staff have current first aid certificates and 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.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Medication storage and prescribing documentation meets guidelines and current legislative requirements. The NM reported that prescribed medications were delivered to the facility and checked on entry. The medication area, including controlled drug storage evidences an appropriate and secure medicine dispensing system. The controlled drug register was maintained and evidenced six monthly physical stock takes and weekly controlled drug checks. The medication fridge temperatures were conducted and recorded. Regular medications are appropriately recorded when given.</p> <p>All staff who administer medicines have current medication competencies. Administration records were maintained, as were specimen signatures. Staff education in medicine management has been conducted.</p> <p>Residents who self-administer medicines do so according to policy.</p> <p>Medicine charts evidenced residents' photo identification, medicine charts were legible, as required (PRN) medication was identified for individual residents and correctly prescribed, three monthly medicine reviews were conducted and discontinued medicines were dated and signed by the GPs. The residents' medicine charts recorded all medications a resident was taking. A staff member was observed administering medications and followed the correct procedure. The two areas requiring improvement from last certification audit have been met.</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. 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 demonstrate 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>The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes. Residents and family members expressed satisfaction with the care provided. Interventions sighted in care plans were consistent with best practice and reflected the actions points generated during the assessment process.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>In interview, the activities coordinator (AC) confirmed the activities programme meets the needs of the residents and the service has appropriate equipment. Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. The hospital resident observes activities that were identified as of interest to the resident, on assessment. There is a planned monthly activities programme that matches the skills, likes and interests evidenced in residents' assessment data. Activities reflect ordinary patterns of life and include normal community activities. Regular exercises and outings are provided for those residents able to partake. Group activities are developed according to the needs and preferences of the residents who choose to participate. Residents and family interviews confirmed satisfaction with the activities programme. Residents' activities plans are current and reviewed six monthly.</p> <p>The residents' meeting is held monthly. Meeting minute's evidence the activities programme is discussed.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plan evaluations include a reassessment of the interRAI assessment tool. The time frames in relation to care planning evaluations are documented in policies and procedures (refer to criterion 1.2.3.3). The long term care plans record the required intervention for the needs identified. In interviews, residents and family confirmed their participation in care plan evaluations.</p> <p>Activities care plan reviews were conducted six monthly in the sample of files reviewed.</p> <p>Care staff document progress notes on every shift for rest home residents and the hospital resident. Registered nurse entries in progress notes were noted to be weekly or more frequently when required. When resident's progress was different than expected, the RN contacted the GP, as required. Short term care plans were utilised for all short term care issues. Short term care plans included goals, intervention and evaluations and sign off by the RN when the problem has resolved. This was an area requiring improvement and has been met. The family were notified of any changes in resident's condition, confirmed at family interviews, however this is not consistently recorded on adverse event forms (refer to 1.1.9.1).</p> <p>There was recorded evidence of additional input from professionals, specialists or multi-disciplinary sources, if this was required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted at the entrance to the facility. There have been no building modifications since the last audit. Hot water temperature monitoring evidenced monthly monitoring is completed and all temperatures were within the safe hot water temperature range. This was an area requiring improvement at last certification audit and this is now fully attained. The facility's maintenance is conducted following any reactive maintenance issues, following environmental audit findings and according to the preventative maintenance plan. Maintenance at the facility is completed by persons from the board and by external contractors. External contractors are used for plumbing, electrical and other specialist areas.</p> <p>Medical equipment calibration/performance is performed annually by an external contractor. There is safe storage of medical equipment. Electrical equipment safety is conducted.</p> <p>Care staff interviewed confirmed: they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.</p> <p>Corridors are wide enough for residents to pass each other safely. Safety rails are secure and are appropriately located. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs. The external areas (patios and gardens) are maintained and are appropriate to the resident groups and setting. There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required.</p>

<p>Standard 3.1: Infection control 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>FA</p>	<p>Wyndham Rest Home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The NM is the designated infection control nurse with current job description for this position. Infection control education is provided for all new staff on orientation and at the in-service education. The infection control programme has been reviewed and the previous area requiring improvement has been met.</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 surveillance policy identifies the requirements around the surveillance of infections. 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 evidenced the residents' who were diagnosed with an infection had short term care plans.</p> <p>Monthly surveillance analysis is completed and reported at monthly staff meetings. 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 NM 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 one hospital level resident using restraint. 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.</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.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	There are policies and procedures on adverse events and open disclosure. Staff are aware of their responsibility to notify family/enduring power of attorney of any accidents/incidents that occur. Review of accident/incident forms evidenced that information of the adverse event is not consistently communicated to the family and the resident, when this is required. Ten adverse event forms were reviewed. Four of the ten adverse event forms reviewed evidenced the family were not notified of the event occurring.	There is inconsistency in recording the notification of adverse events to family and residents.	Provide evidence adverse events are communicated to family and residents to ensure full and frank open disclosure is practised. 30 days
Criterion 1.2.3.3	PA Low	Systems are in place for reviewing and updating policies and procedures. The nurse manager has commenced updating and	Not all policies and	Provide evidence of

<p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>		<p>reviewing policies and procedures, however there are policies and procedures still requiring review to comply with good practice. The care planning policy and the interRAI policy specify timeframes for completion of assessments and initial and long term care plan completion timeframes (refer to criterion 1.3.3.3).</p>	<p>procedures are current.</p>	<p>comprehensive review of all policies and procedures.</p> <p>180 days</p>
<p>Criterion 1.2.4.3 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>	<p>PA Moderate</p>	<p>Staff report adverse events and the events are reviewed by the RN or the NM. Eight of ten adverse event forms relating to residents' possible head injury as a result of a fall, did not record assessments and observations were not conducted in timely manner.</p>	<p>Neurological observations are not consistently completed when there is a risk of head injury following adverse events.</p>	<p>Provide evidence timely observations are conducted and recorded where there is a risk of head injury following adverse event.</p> <p>30 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>Policies and procedures record timeframes relating to requirements of assessments and completion of long term care plans. In the residents' files reviewed there was evidence that the timeframes of completion of interRAI assessments and completion of long term care plans were not consistently completed within the required timeframe.</p>	<p>Service provision timeframes are not consistently being adhered to.</p>	<p>Provide evidence service provision timeframes are adhered to.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.