# Nazareth Rest Home Limited - Nazareth 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 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Nazareth Rest Home Limited

**Premises audited:** Nazareth Rest Home

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

**Dates of audit:** Start date: 25 October 2016 End date: 26 October 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:** 43

# 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** |
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|  | 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 |
|  | 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

Nazareth rest home is owned by Sisters of St Joseph of the Sacred Heart Trust. The service is certified to provide rest home and hospital level care for up to 46 residents. On the day of the audit there were 43 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of resident’s and staff files, observations and interviews with residents, relatives, staff and management.

The care home manager is appropriately qualified and experienced. Feedback from residents and relatives is positive.   
Two of the two shortfalls identified at the previous audit have been addressed. These were around internal audit reporting and resident assessment.

This surveillance audit has identified that improvements are required around incident form reporting, care plan documentation, monitoring and evaluation of care, activities documentation and aspects of medication management.

## Consumer rights

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| 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. |

Residents and family are well informed including of changes in resident’s health. The care home manager and clinical manager have an open door policy. Complaints processes are implemented and complaints and concerns are managed and documented and learning’s from complaints shared with all staff.

## Organisational management

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| 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. |

There is an established and implemented quality and risk management system that supports the provision of clinical care and support. Regular resident/relative satisfaction surveys are completed and there are regular resident/relative meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. An orientation programme provides new staff with relevant information for safe work practice. The in-service training programme covers relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff input into rostering.

## Continuum of service delivery

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| 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. |

Resident records reviewed provide evidence that the registered nurses utilise the InterRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six monthly. Resident files include three monthly reviews by a general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner/nurse practitioner.

The activities programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on site and the menu is reviewed by a dietitian annually. All residents' nutritional needs are identified and documented. Choices are available.

## Safe and appropriate environment

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| 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. |

The building holds a current warrant of fitness.

## Restraint minimisation and safe practice

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| 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. |

There is a restraint policy that includes comprehensive restraint procedures including restraint minimisation. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There are no residents with restraints and six enablers being used (all bed rails). Enabler use is voluntary.

## Infection prevention and control

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| 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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the infection control coordinator. There is a suite of infection control policies and guidelines that meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| **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 | 12 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 35 | 0 | 3 | 2 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **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 number of complaints received each month is reported monthly to the board. The complaints information is provided to resident/relatives at entry and prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Two complaints reviewed for 2016 included documented follow-up. Outcomes of investigations included a review of rosters and discussion at staff meetings of issues raised.  Discussion with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints reviewed were well documented including investigation, follow-up letter and resolution. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. The manager and registered nurse confirm family are kept informed. Relatives stated they are notified promptly of any incidents/accidents. Resident meetings encourage open discussion around the services provided (meeting minutes sighted).  Incident forms reviewed identified that family were notified. Families provide instructions to staff regarding contact should an accident/incident occur.  There is an interpreter policy and contact details of interpreters. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Nazareth rest home is owned by The Sisters of St Joseph of the Sacred Heart, who manage three aged care facilities. Nazareth rest home provides care for up to 46 rest home and hospital (geriatric and medical) residents. There are 18 rest home specific beds and 28 dual-purpose bed level of care residents. On the day of audit there were 43 residents, 30 rest home and 13 hospital. All residents were under the ARC agreement. There were no respite residents and no residents under the medical component of the certificate.  The service has a business plan which is reviewed annually. The business plan identifies the purpose, values and scope of the business. The service has quality goals which are reviewed regularly. The manager has had overall responsibility for the three facilities for three years, with specific responsibility for Nazareth rest home since February 2016. The manager is supported by an experienced clinical manager (registered nurse) with a background in aged care. The manager has completed at least eight hours of professional development including regional provider meetings. |
| 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 | The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Policies are current and staff are informed of updates and changes. As part of quality improvement processes and service review, Nazareth has reviewed staffing and made changes such as increased registered nurse cover. The service is also in the initial stages of introducing a computerised care planning package. Computerised medication management software has been implemented and all polices are in the process of review and update to ensure alignment to new systems.  There is a documented business and quality plan as well as a six monthly review of progress. Monthly combined meetings of quality, health and safety, and infection control as well as very frequent management meetings (up to three times a week) ensure that key components of the quality management system are discussed and communicated to staff. Meeting minutes reflect discussion; internal audit outcomes and audit outcomes are posted up in the staff room. The service has addressed this previous audit finding. Internal audits are completed according to the schedule. Corrective action plans are developed when service shortfalls are identified.  Monthly reports to the board from the general manager are comprehensive.   There is a hazard management, health and safety and risk management programme in place. There are facility goals around health and safety. The health and safety committee meets monthly and there is a current hazard register. Falls prevention strategies are in place. |
| 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. | PA Low | The service documents and analyses incidents/accidents. Individual incident reports are completed for incident/accident with immediate action noted. Not all identified pressure injuries had a documented incident form. Incident reports are assessed for a means to prevent recurrence before being signed off. All incident forms reviewed documented immediate follow-up by a registered nurse. Not all head injuries/unwitnessed falls included neurological observations (link to 1.3.6.1). Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| 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 | A register of practising certificates is maintained.  Five staff files reviewed (two registered nurses including the clinical nurse manager, and three caregivers) included appropriate employment documentation and up-to-date performance appraisals and documentation.  The service has an implemented orientation programme in place that provides new staff with relevant information for safe work practice including around caring for those with dementia. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.   There is an annual education schedule that is being implemented. In addition, opportunistic education is provided during handovers as well as additional training around the newly implemented medication management software. Registered nurses (RNs) are provided with suitable training such as palliative care, wound care and pain management. A competency programme is in place such as medication and restraint. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy aligns with contractual requirements and includes skill mixes. The service has recently reviewed the staffing levels and has increased RN hours. This has allowed the clinical nurse manager to take on a supervision and monitoring role. Rostered and rotating shifts have been introduced for all staff following a significant change management process.  There is at least one registered nurse on duty at all times over the 24 hour period. The clinical manger is a registered nurse and works 40 hours per week. Interviews relatives and residents all confirmed that staffing numbers were good. Caregivers interviewed stated that they have sufficient staffing levels. |
| 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 | The service uses individualised medication packs which are checked-in on delivery. A registered nurse and medication competent caregiver were observed administering medications correctly. Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements. Resident photos and documented allergies or nil known were on all ten medication charts reviewed. An annual medication administration competency was completed for all staff administrating medications and medication training had been conducted.  There is a self-medicating resident’s policy and procedures in place. There were currently no residents who self-administered medications.  Medications are charted electronically by the GPs using an electronic medication management system. ‘As required’ medication was reviewed by a registered nurse each time prior to administration and the reason for administration was documented. The efficacy of the medication was not always documented and oxygen was being administered without a prescription. Medication charts reviewed identified that the GP had reviewed the resident three monthly. |
| 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 | All meals at Nazareth Rest Home and Hospital continue to be prepared and cooked on site. There is a four weekly winter and summer menu approved by the dietitian. Meals are prepared in a well-appointed kitchen adjacent to the dining room and served directly to the residents. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurse or clinical nurse leader. Supplements are provided to residents with identified weight loss issues. Resident meetings and satisfaction surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. The service has fully implemented the InterRAI assessment process. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives. Paper based assessments and InterRAI assessments are reviewed at least six monthly. The service has addressed this previous audit finding. |
| 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 | All resident files reviewed had a documented care plan. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.  Interventions for behaviour that challenges were not always documented. Monitoring charts were in place but monitoring was not always documented for a range of monitoring needs.  Continence products are available and resident files include a three-day 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 by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.  Wound assessment, wound management and evaluation forms and short-term care plans were in place for wounds. Wound charts were documented for seven wounds (four skin tears, two chronic ulcers and one surgical wound). There were two facility acquired pressure injuries and two non-facility acquired pressure injuries. Wound care charts were not consistently documented. |
| Standard 1.3.7: Planned 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. | PA Low | Nazareth rest home continues to provide a varied and well attended activity programme for residents. The service employs one activity coordinator five days a week (25 hours) as well part-time pastoral carers. The pastoral carer assists with activities and conducts interdenominational church services and one-on-one meetings with residents. A priest conducts a catholic mass once a week. The activities staff provide an activities programme over seven days each week. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned for the day were displayed on noticeboards around the facility. As a result of resident consultation, the activities provided have been reviewed and now includes sensory activities, a new craft programme and a range of new games and activities.  Residents are encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. The service has a van that was used for resident outings. Residents were observed participating in activities on the days of audit. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.  Not all residents had a diversional therapy plan and not all plans had been updated to reflect resident need. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | In files sampled, care plan evaluations were documented by the registered nurses. Six monthly multi-disciplinary reviews (MDT) were completed by the registered nurse with input from caregivers, the GP, the activities coordinator and if applicable, the physiotherapist. Family are invited to attend the MDT review. Files sampled also had short-term care plans available to focus on acute and short-term issues. Not all care plans had been updated when resident needs changed. |
| 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 service has a current building warrant of fitness that expires on 22 June 2017. |
| 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 coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Infection control data is collated monthly and reported at the quality meetings. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy.  There were no residents with restraint in the service. Residents’ files for six residents with enablers showed that enabler use is voluntary (link to 1.3.6.1 for care plan interventions). |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| 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. | PA Low | Policies and procedures are in place to guide staff around the management, monitoring and recording of incidents and accidents. Staff interviewed were all able to describe the management and documentation required. Adverse events including falls, skin tears, bruising and behaviours were reported via the incident reporting processes. One of three current pressure injuries had an associated incident form. | Two of three identified pressure injuries did not have a documented incident form. | Ensure that all pressure injuries are recorded through the incident form process.  60 days |
| Criterion 1.3.12.1  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. | PA Moderate | There is a comprehensive range of policies and procedures in place to guide staff around all aspects medication management. The service has a comprehensive training programme and competencies in place to ensure staff provide a safe medication service. Medication administration was observed during the audit and practice was appropriate during these medication rounds. The efficacy of ‘as needed’ analgesia was not always documented and regular oxygen administered for one resident had not been prescribed. | (i) One resident had been administered oxygen which had not been prescribed.  (ii) ‘As needed’ analgesia did not have the efficacy documented for three residents. | (I) Ensure that all medication administered is prescribed.  (ii) Ensure that ‘as needed’ medications have the outcome documented.  30 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 | Five resident files were reviewed for this audit. All residents had a care plan in place. The service did not always document the interventions needed to address or monitor the issues identified. Care staff interviewed were able to describe the care and support needed (hence the low risk). Six of eleven wound management plans included all required documentation. | (i) Two residents with incident forms for a head injury did not have documented neurological observations.  (ii) One resident in the rest home with behaviours that challenge did not have interventions documented to manage the behaviour.  (iii) Monitoring of residents was not consistently documented including; turning charts for two hospital residents, and weight charts for two residents (one hospital and one rest home).  (iv) One resident with an enabler did not have the risks associated with its use in the care plan.  (v) Wound care plans were not comprehensively documented including; five of eleven wounds did not have a comprehensive management plan (seven wounds and four pressure injuries); four of eleven wounds did not have a documented formal assessment (two wounds and two pressure injuries); the evaluation of five of eleven wounds (two PIs and two wounds) did not include a documented review of size, depth and exudate by using the service evaluation forms. | (i) Ensure resident with a head injury have documented neurological observations  (ii) Ensure care plan interventions are documented for behaviour that challenges  (iii) Ensure ongoing monitoring is documented as directed by care plans  (iv) Ensure that the risks associated with enablers are documented in the care plan  (v) Ensure that wound care plans follow service policy and procedure with a formal assessment plan and evaluations.  30 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | The service has employed a new activity staff member. The staff member is in the process of ensuring that activity plans are up-to-date and reflect resident need. This process is currently in the process of implementation and not all resident activity plans are up-to-date. | Two of three hospital residents’ activity plan had not been updated to reflect resident need. Of the two rest home resident files reviewed, one did not have an activity plan and one had not been updated to reflect resident need. | Ensure that all residents have an individual activity plan and that activity plans are updated to reflect resident needs.  60 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Low | Five care plans reviewed all documented at least six monthly reviews of clinical care, and evaluation of progress against set goals. Changes to care needs between the reviews were reflected in the care plans for two hospital and two rest home resident files reviewed. Care staff interviewed were able to describe care needs and handover notes reflected the changes in need. | The care plan for one hospital resident, who had commenced the palliative care journey, had not been updated to reflect current needs. | Ensure care plans are updated with changes to care.  60 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.

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End of the report.