# Oceania Care Company Limited - The Oaks 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](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:** Oceania Care Company Limited

**Premises audited:** The Oaks Rest Home and Village

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

**Dates of audit:** Start date: 12 April 2017 End date: 13 April 2017

**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:** 88

# 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 |
|  | 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

The Oaks Lifestyle Care and Village provides rest home and hospital level care for up to 102 residents. There were 88 residents at the facility on the first day of the audit.

This surveillance audit was conducted against the relevant aspects of the Health and Disability Services Standards and the facility’s contract with the district health board. The audit process included a review of policies and procedures; a review of resident and staff files; observations and interviews with residents, a family member, management, staff and a general practitioner.

There were two areas requiring improvement from the last certification audit relating to recording on care plans and medication documentation and reviews have been closed out.

There is one area for improvement identified at this audit relating to meeting timeframes for assessments and care planning.

## 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. |

Information regarding the Health and Disability Commissioner‘s Code of Health and Disability Services Consumers‘ Rights (the Code), the complaints process and the nationwide Health and Disability Advocacy Service is brought to the attention of residents and their families on admission to the facility. This is also accessible throughout the facility. Residents and family confirmed their rights are met, staff are respectful of their needs and communication is open and appropriate.

The business and care manager is responsible for the management of complaints. Complaints are managed within the required timeframes and an up-to-date 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. |  | Standards applicable to this service fully attained. |

The Oaks Lifestyle Care and Village is part of Oceania Care Company Limited and is responsible for the services provided at this facility. A business plan and quality and risk management system document the scope, direction, goals, values and mission statement of the facility.

The quality and risk management system supports the provision of clinical care at the service. The facility has an incident and accident management system that records and reports all adverse, unplanned or untoward events. This includes the required statutory and regulatory reporting. Systems are in place for monitoring adverse events and the quality of services provided. Quality and risk performance is reported through meetings at the facility and monitored by the organisation‘s management team through the business status and clinical indicator reports. Corrective action plans are documented with evidence of the resolution of identified issues.

The service is managed by a business and care manager who is supported in their role by a clinical manager. The clinical manager is responsible for the oversight of the clinical service provision in the facility. Human resource policies are current and implemented. Registered nurses are on duty 24 hours a day and are supported by adequate levels of care and allied health staff across the facility. On-call arrangements for support from senior staff are in place.

## 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. |

The residents’ long-term care plan interventions are detailed to address the residents’ care needs and evaluated when a resident’s condition alters or six monthly. The short-term care plans are developed for short-term problems and evaluated in a timely manner.

Planned activities are appropriate to the needs, age and culture of the residents. Residents reported activities are enjoyable and meaningful to them.

The medicine management system is documented and implemented. Staff medication competencies are maintained. There were no residents self-administering medications at the facility on audit days.

Food services meet food safety guidelines and legislation. The individual food, fluids and nutritional needs of the residents are met.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

There is a current building warrant of fitness on display. There have been no building modifications since the last audit.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The restraint minimisation and safe practice policies and procedures record the safe use of restraints and enablers and comply with this standard. There were four residents using restraints or eight residents who had requested the use of enablers at the facility during the on-site audit. Staff interviewed demonstrated an understanding of restraint and enabler use and receive ongoing restraint education.

## 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 activities are appropriate to the size and scope of the services provided. Infection control management systems are in place to minimise the risk of infection to residents, visitors and staff. Infection data is collated monthly, analysed and reported to Oceania Care Company Limited support office, management and staff. Results of the surveillance are acted upon, evaluated and reported.

## 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 | 15 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 0 | 1 | 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](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).

|  |  |  |
| --- | --- | --- |
| **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 facility’s complaints policy, procedures and timelines are in line with the Code, including the correct timeframes for responding to a complaint. Complaint forms were observed to be available in the facility. Family and residents interviewed confirmed they know how to lodge a complaint. The BCM is responsible for the management of complaints.  The complaints reviewed had been managed in line with policy and Right 10 of the Code and included signoff and implementation of corrective actions when required. An up-to-date complaints register is maintained.  The BCM reported that there have been no investigations by the Health and Disability Commissioner or any other external agencies since the last audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An information pack provided to residents and their families on admission includes information about the facility, the Health and Disability Commissioner‘s Code of Health and Disability Services Consumers‘ Rights (the Code), the complaints process and the nationwide Health and Disability Advocacy. This information is also available throughout the facility and discussed at resident meetings.  The resident admission agreement, signed by residents or their representative on entry to the service, details those services that are included in service provision and those the resident is required to pay for.  Two monthly resident meetings inform residents of facility activities and updates. The resident meeting minutes reviewed evidenced a variety of subjects are discussed. They also provide an opportunity for residents to discuss issues and concerns with the business and care manager (BCM). Minutes of resident meetings were sighted.  A review of residents’ clinical files evidenced timely and open communication with residents and family members. Communication with family members is recorded in the progress notes.  Staff, residents and family confirmed that residents’ rights are being met, staff are respectful of residents’ needs, and residents and their families are kept fully informed in a timely and appropriate manner. This includes contacting relatives regarding any change in a resident’s condition or if any adverse event occurs. This was evidenced in the resident files reviewed.  An information poster, in multiple languages, advises that interpreter services can be accessed through language line if required. There were no residents at the facility requiring interpreter services on audit days. Staff interviewed confirmed that in the past staff or a resident’s family member had provided interpreter services when required. |
| 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 Oaks Lifestyle Care and Village is part of Oceania Care Company Limited (Oceania) and is responsible for the services provided at this facility. The Oceania executive management team provide support to the facility and the regional clinical manager provided support during the audit.  Communication between the facility and the Oceania regional clinical manager takes place on at least a monthly basis. The monthly business status report provides the executive management team with progress against identified indicators.  Oceania has a documented mission statement, values and goals. These are communicated to residents, staff and families through posters on the wall, information in booklets and in staff training.  The facility is managed by a business and care manager (BCM) who has 35 years business management experience and has been in this position for 3 years. The clinical service delivery is overseen by the clinical manager (CM) who is a registered nurse (RN). The CM has been in this position for three years.  The facility has 105 beds and can provide care for up to 102 residents under the facility’s current certification. There were 88 beds occupied on the first day of the audit. This included 46 residents requiring rest home level care and 42 residents requiring hospital level care. Of these, two residents, assessed as requiring rest home level care, were identified as being under the young people with disability contract; and one resident, assessed as requiring hospital level care, was identified as under the long-term chronic conditions contract. |
| 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 facility has implemented the Oceania documented quality and risk management framework to guide practice. The facility implements Oceania policies and procedures to support service delivery. All policies have evidence of timely review and are current. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Staff interviews confirmed that policies are available to staff and that they are informed of new and revised policies, through staff meetings. Staff sign to confirm that they have received these.  Oceania has processes in place for the facility to implement the quality and risk management system and monitor the key components of service delivery. This includes reporting systems that demonstrate the collection; collation and identification of trends; and analysis of data. Results are reported to staff.  An internal audit schedule is implemented and results are communicated to staff and where relevant and appropriate to residents. The 2016 family and resident satisfaction survey shows satisfaction with services provided and this was confirmed through resident interviews. Opportunities for improvement arising from the survey have been implemented. The satisfaction survey results are not compared with previous survey results for comparison of data or reported to Oceania. The March 2017 survey has been deferred until May 2017 to accommodate feedback on the recent outsourcing of laundry services.  The facility has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence that hazard identification forms are completed when a hazard is identified, hazards are addressed, and risks minimised or isolated. Health and safety is audited monthly with a facility health check completed by the clinical and quality manager. Staff interviews confirmed that staff have training related to health and safety processes and an awareness of the importance of reporting hazards, accidents and incidents promptly. |
| 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 | The BCM confirmed an understanding of the circumstances and events that require the facility to report to and notify statutory authorities. Where an authority has been notified, this is documented and retained in the relevant file. There have been two notifications to HealthCERT.  Staff interviews confirmed that the facility provides an environment that encourages and facilitates staff to recognise and report errors or mistakes. Staff records reviewed demonstrated that staff receive education during orientation on the incident and accident reporting process. Staff interviewed confirmed an understanding of the adverse event reporting process and their obligation to documenting all untoward events.  Incident reports selected for review identified that family and the GP had been notified and that incidents and accidents had been followed up and signed off. The information gathered is regularly discussed at staff meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities. |
| 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 | Oceania human resource policy and processes are in place and have been implemented. All RNs hold current annual practising certificates (APC). The current visiting practitioners’ practising certificates, including: general practitioners; pharmacists; dietitian and podiatrist, are current. Staff files include employment documentation. An annual appraisal process is in place and staff interviews and files reviewed confirmed that all staff have received a current performance appraisal.  A comprehensive orientation programme is available for staff and staff files show completion of orientation and that the competency sign off process is completed. Staff interviews confirmed that orientation was appropriate and sufficient for their role.  Mandatory training is identified on an Oceania wide training schedule. A training and competency file is held for all staff and an electronic spread sheet of all training and orientation undertaken is maintained. This also serves as a bring-up system for compulsory training and competency requirements. The training register and training attendance sheets show staff completion of annual competencies, including medication.  Education and training hours exceed eight hours a year for all staff reviewed. Six RNs have fully completed the interRAI training and one RN is undergoing training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staffing levels are managed to ensure the numbers and appropriate skill mix of staff are available to meet the number of residents, current and anticipated workloads, as well as the levels required due to changes in the services provided.  Rosters reviewed reflected staffing levels that meet resident acuity, bed occupancy and the staffing requirements as per contract in relation to the level of care required. There is a process in place to source additional staff in periods of unplanned absences.  The BCM is available on call and there are systems in place to obtain additional RN support if required.  Residents and families interviewed confirmed that there is sufficient staff to meet the residents’ needs |
| 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. | FA | The medicine management system is documented and implemented and complies with legislation, protocols and guidelines. The service uses pharmacy pre-packaged medicine that is checked by the RN on delivery. A computer based medication system is used. Weekly checks and six-monthly controlled drugs stocktakes are conducted. The controlled drugs registers were correct and current. The medication fridge temperatures are monitored. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are stored appropriately.  The staff administering medication complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled.  There were no residents who self-administered medications on audit days. Policies and procedures are in place to ensure safe storage and compliance in relation to self-administration of medications.  The area requiring improvement from last certification around three monthly medicine reviews, documenting allergies and correct prescribing of as required (PRN) medicines, has been met. |
| 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 | Meals are prepared on site and served in the respective dining rooms. The seasonal menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the chef confirmed awareness of the dietary needs of residents. The residents’ dietary profiles are developed on admission and identify the residents’ dietary requirements and preferences. The dietary profiles are communicated to kitchen staff on a resident’s admission to the facility, when a resident’s dietary needs change and when dietary profiles are reviewed six monthly. Supplements are provided to residents with identified weight loss issues. Residents’ weights are monitored monthly or more frequently if required.  The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.  The residents and family interviewed indicated satisfaction with the food service. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The long and the short-term care plans are developed by the RNs. The care plan interventions in both the long-term and the short-term care plans are detailed to address the desired goals/outcomes of the residents. Changes in a resident’s condition are reported in a timely manner to the GP, as confirmed at GP interview.  Monitoring forms are in use, such as: weights; vital signs; wounds and challenging behaviour. The wound assessments and wound management plans are in place for residents who require them. There is access to specialist services when needed. Referrals are initiated by the GP or by the RNs.  Clinical supplies are available and staff confirmed they have access to medical supplies and equipment. Residents and family members interviewed reported satisfaction with the care and support they are receiving. |
| 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. | FA | The residents’ activities programme is developed by the diversional therapist (DT). The activities programme was implemented five days a week, however, following residents’ request for activities to be provided more than five days a week, the activities programme commenced to be provided from Monday to Saturday the week of audit.  The residents’ activities assessments are conducted by the DT within the three weeks of the residents’ admission to the facility. Residents’ interests are gathered during an interview with the resident and their family. The activity care plan is part of the long-term care plan and reflects the residents’ preferred activities. There was evidence the activities staff are part of the evaluation process.  The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging in a variety of activities and outings.  Resident meetings are conducted bimonthly and a meeting was held on day of audit. Past minutes of residents’ meetings are displayed on notice board for resident and family information. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The long-term and the short-term care plans are evaluated in a comprehensive and timely manner. The evaluations include the residents’ degrees of achievement towards meeting the desired goals/outcomes. Residents’ responses to the treatment regime is documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved.  The short-term care plans are developed when needed and record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved. The previous area requiring improvement relating to short-term care plans and care plan evaluations has been met. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness displayed in the entrance of the facility. There have been no any alterations to the building since the last audit. |
| 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 surveillance policy identifies the requirements around the surveillance of infections and the type of surveillance to be undertaken. Infection logs are maintained for infection events and collated monthly by the clinical manager. The clinical manager is the infection control nurse. The collated infection control information is communicated as clinical indicators to the Oceania support office and to management and staff. The clinical indicators are reviewed by the Oceania clinical quality team and reported to the Oceania board.  Residents’ files evidenced the residents diagnosed with an infection had short-term care plans in place. The GP interview confirmed any suspected infection is reported to the GP in a timely manner.  In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the 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.  In interview, the clinical manager confirmed there had been no outbreaks at the facility since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The Oceania restraint minimisation and safe practice handbook and policies comply with this standard and relevant legislation.  The restraint coordinator is the clinical manager. A signed position description was sighted. There were four residents using restraints and eight enablers requested to be used by residents on audit days. The restraint register is maintained and current. The required documentation relating to restraint and enabler use is recorded. The residents’ documentation relating to enabler use confirmed the enablers are requested by the residents and the least restrictive options to promote the residents’ independence and safety is used.  The national restraint authority group meeting review of restraint practices annually including: the type of restraints used; extent of restraint use and trends; progress in reducing restraint use nationally; adverse outcomes from restraint use; and staff compliance of the restraint standard. Nationally the data shows there has been significant reduction in restraint use. Staff receive restraint education via the Oceania study days and RN study days. |

# 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 1.3.3.3  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 | Review of residents’ files evidenced the initial risk assessments, including interRAI assessments, were not consistently conducted in the required timeframes. The initial risk assessments were not completed in the required timeframe in five of the eight files reviewed. The interRAI assessments were not completed within three weeks of the residents’ admissions in the two of the eight files reviewed. The six monthly interRAI reassessments were completed in the files reviewed.  The initial care plans were not consistently completed in the required timeframe in three of the eight files reviewed.  The long-term care plans were not completed within three weeks of admission in three of the eight files reviewed.  The GP assesses the new residents within the required timeframe and indicates if the resident is stable to be medically reassessed in three months’ time or if the GP requests to see the resident monthly. The review of the hospital tracer evidenced this request for monthly medical reviews was not followed. Additional sampling of eight clinical files was under taken relating to GP requests to reassess residents more frequently than three monthly. Of the additional eight files reviewed these requests were not followed in six residents’ files. | Clinical care timeframes are inconsistently adhered to when required. | Ensure timeframes relating to clinical care of residents are adhered to as per policy, Health and Disability Standards and the ARC contract.  30 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.