

# Tranquillity Bay Care Limited - Tranquillity Bay care

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## 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 HealthShare 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:** Tranquillity Bay Care Limited

**Premises audited:** Tranquillity Bay Care

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 21 September 2017 End date: 22 September 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:** 33

# Executive summary of the audit

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## 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

Tranquillity Bay Care can provide care for up to 34 residents requiring rest home level care. The service also has residents requiring care under short-term contracts (respite care). This surveillance audit is conducted against the Health and Disability Service Standards and the service contract with the District Health Board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

Most requirements identified at the previous audit have been met. These include improvements in relation to regular meetings held; policies and procedures; documentation of assessments and wound care. An improvement is still required regarding performance appraisals.

Further improvements identified at this audit relate to organisational plans; reference checking; review of short-term care plans; documentation of administration of controlled drugs and food safety training.

## 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.
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Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents demonstrate they are provided with adequate information and that communication is open.

Resident meetings provide feedback and confirm regular communication and involvement. Communication records are maintained. If required, the service will access interpreters from the District Health Board. Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. The complaints register is current.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There is a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed by the management team and quality and risk performance is reported through meetings. The quality and risk management programme includes analysis and discussion of incidents with an internal audit schedule implemented.

There are human resource policies implemented around selection, orientation and staff training. Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

## 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 low risk.
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Service provision is coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a range of life experiences and choices. Resident's care planning is changed according to the needs or when progress is different from expected. The service uses short-term care plans for acute problems.

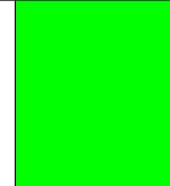
The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Medication areas, including controlled drug storage, evidence a secure medicine dispensing system. Review of staff competencies confirms all staff have current medication management competencies.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being 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.

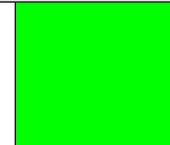


Standards applicable to this service fully attained.

All building and plant comply with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes electrical checks and calibration of equipment. There have been no changes to the facility 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.

Restraint minimisation policy and procedures including definitions of restraint and enablers are congruent with the restraint minimisation and safe practice standard.

There are no residents using restraints or enablers.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. Surveillance is completed at monthly intervals and contributes to the quality improvement within the facility.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	5	0	0	0
Criteria	0	36	0	6	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service operates a complaints process that references to Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The service has an up-to-date complaint register which identifies the date of the complaint, the complainant, description of the issue and the actions taken.</p> <p>A resident complaint was reviewed. The complaint is on the register and timeframes as per the Code have been met to resolve the issue. The manager confirms that there have been no complaints made to external authorities.</p> <p>Residents and family interviewed confirmed they have had the complaints procedure explained to them and they know how to make a complaint if required. Staff are aware of their responsibility to record and report any resident or family complaint they may receive.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is provided. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in resident records reviewed.</p>

<p>conducive to effective communication.</p>		<p>Family contact is recorded in residents' records on the newly implemented family communications record. The files sampled document that each family has been rung over the past six months to update family around progress and to gain input into care planning. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to participate in the entry process for their family member and in ongoing care options.</p> <p>Interpreting services are available from the District Health Board if required. The information pack is available in large print and this can be read to residents.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. All admission agreements sampled were signed on the day of admission.</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>PA Low</p>	<p>The organisation is owned and operated by Tranquillity Bay Care Limited. The strategic direction for the organisation is documented. The purpose, values, scope, direction, and goals of the organisation are identified with review being completed by the manager and operations manager. The business plan has been progressed to include a new build with a project plan in place. Meetings are held to review progress. The review of the plan is included as part of the meeting schedule. A quality and risk schedule is documented and reviewed at the management meeting. The quality plan is currently being developed in line with the review of the business plan which is required to be completed.</p> <p>There is an established organisational structure, with the sole director (manager) being supported by an operations manager.</p> <p>The director known as the manager has a background in administration and accounting and has been working in the aged care industry for seven years. The manager is supported by a clinical manager who has over seven years' experience in aged care. The operations manager provides support for property development, public relations and refurbishment of the site.</p> <p>On the day of audit, there were 33 residents in the facility including three who are receiving respite level care. One resident is under a mental health contract.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk</p>	<p>FA</p>	<p>There is a quality and risk management framework that is documented to guide practice (refer 1.2.1).</p> <p>The service implements organisational policies and procedures to support service delivery. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hard copy. All policies are subject to reviews as required with policies reviewed over the last 18 months and reflecting a mental health focus</p>

<p>management system that reflects continuous quality improvement principles.</p>		<p>where required. The improvement required at the previous audit has been met.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues documented. Internal audits around pressure injuries are audited internally as part of the wound care plan audit. There is evidence of improvements that have been put in place to improve resident care, satisfaction and service delivery. A quality indicator data form summarizes quality data monthly and there is monthly trend analysis around falls, infections, incidents and accidents and others.</p> <p>The schedule of meetings is as follows: monthly quality health safety meetings; monthly staff; three monthly resident/family; two weekly management and other meetings as required for example maintenance and kitchen staff meetings. Meetings are now held regularly and the improvement required at the previous audit has been met. Staff report that they are kept informed of quality improvements.</p> <p>The last satisfaction survey for family and residents shows that they are satisfied with services provided and this was confirmed by residents and family interviewed.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly.</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>FA</p>	<p>The manager is aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks and changes in key clinical staff.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand the adverse event reporting process and can describe the importance of recording near misses.</p> <p>Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place. A review of incidents confirmed that all include sign off by the clinical manager with improvements noted in meeting minutes if required.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>PA Low</p>	<p>The clinical manager and registered nurse hold current annual practising certificates along with other health practitioners involved with the service.</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>Staff files include appointment documentation including documented applications; signed contracts and job descriptions. An improvement is required to documentation of references for new staff.</p> <p>There is a staff appraisal process however; an improvement is still required to ensure that all staff have had an annual performance appraisal as required.</p> <p>All staff complete an orientation programme and health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Health care assistants confirmed their role in supporting and buddying new staff.</p> <p>Annual competencies are completed by care staff including medication management. Evidence of completion of competencies is kept on staff files.</p> <p>The organisation has an annual training schedule documented with some on line sessions available and completed by staff in a time that suits them. Staff attendances are documented for training provided. Education and training hours are at least eight hours a year for each staff member. The clinical manager and registered nurse have completed interRAI training with certificates sighted.</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>	<p>FA</p>	<p>The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.</p> <p>There are 33 staff including the clinical manager and registered nurse who provide 66 hours a week oversight; clinical care with a registered nurse or clinical manager on site six days a week and on call. The manager is also on call. There are four health care assistants rostered on the morning shift; three health care assistants in the afternoon and two overnight. The diversional therapist and activities staff facilitate the activities programme and household and maintenance staff are employed.</p> <p>Residents and families interviewed confirmed staffing is adequate to meet their needs. Staff stated that they can negotiate with the manager for extra staff if the acuity or numbers of residents increases.</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</p>	<p>PA Low</p>	<p>Medicine management policies and procedures are in place and implemented, include processes for safe and appropriate prescribing, dispensing and administration of medicines. The area is free from heat, moisture and light, with medicines stored in original dispensed packs, in a secure manner. Reconciliation of medication is documented.</p> <p>Medicine charts list all medications the resident is taking, including name, dose, frequency and route to be given. All entries are dated and allergies recorded. All charts have photograph identification with the date</p>

<p>safe practice guidelines.</p>		<p>of the photograph recorded. Three monthly GP reviews are documented.</p> <p>Medication fridges are monitored daily. Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct with two staff signing the controlled drug register; however two signatures are not consistently recorded on the corresponding administration sheet and an improvement is required. Weekly stocktakes are completed.</p> <p>Sharps bins are available for used needles. Unwanted or expired medications are taken to the pharmacy in a locked box. Medication administration was observed at lunchtime and at breakfast time. The staff members checked the identification of the residents, completed checks of the medicines, administered the medicines and then signed off after the resident took the medicines.</p> <p>Education in medicine management is conducted. Medicines management competency testing includes theory and practice. All staff members responsible for medicines management complete annual competencies. Self-administration of medicine policies and procedures are in place and sighted. There are some residents who self-administer their own medication. Each has a competency documented and staff check daily that they have taken their medication.</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>PA Low</p>	<p>There are four cooks. The head cook has completed training and one other cook is to be enrolled in training. A course is being developed for the tea cooks. The head cook provides oversight of food services. The cook interviewed confirms they are aware of the residents' individual dietary needs with these documented in the kitchen. Documentation includes allergies, likes and dislikes.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. Residents state they are satisfied with the food service and reported their individual preferences are met and adequate food and fluids are provided.</p> <p>The kitchen environment is well-lit and uncluttered. There is evidence of kitchen cleaning schedules signed off as cleaning is completed. Fridge, chiller and freezer temperatures are monitored regularly and recorded, as are food temperatures. All food is kept off the pantry floor.</p> <p>There is a seasonal menu with a four-week rotation. Review of residents' files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as special diets, pureed meals along with alternative nutrition appropriate to the residents are available. A dietician is currently reviewing the summer menu prior to use with an email confirming this sighted.</p> <p>There is enough stock to last in an emergency, for three days, for all residents.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All residents are assessed by a needs assessor prior to entry to the service with a copy on file. The improvement required at the previous audit has been met.</p> <p>InterRAI assessments are completed for all residents as part of the entry process and at six monthly intervals. The assessment is updated if changes occur. The improvement required at the previous audit has been met. The assessment is used as the basis of care planning. The resident records sampled confirmed resident and family involvement in the assessment process. The GPs had seen the residents within the required timeframes and documented a medical assessment on admission. The activities assessments had past and current interests documented. Baseline recordings are conducted for weight management and vital signs with monthly monitoring documented.</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>Residents receive adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions are documented for each goal in the long-term care plans. Other considerations such as pain management, dietary likes and dislikes, appropriate footwear and use of hearing aids are included in the long-term care plans.</p> <p>An interview with the GP confirmed clinical interventions are effective and appropriate. Interventions from allied health providers and if required, other District Health Board staff are included in the long-term care plan. This includes interventions documented by the podiatrist and the physiotherapist as sighted during the audit.</p> <p>Residents and family involvement in the development of goals and review of care plans is encouraged.</p> <p>Initial assessments of any wounds are documented with information including size, exudate, depth documented. A review of three assessments and wound plans, and a review of wound assessments and plans for pressure injuries, confirmed that these are well documented and evaluated at each dressing. The improvement required at the previous audit has been met.</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>The activities programme is documented with a diversional therapist and activities coordinator providing activities six days a week from 8.30 in the morning to 6 o'clock at night. There are total of 62 hours a week provided for activities.</p> <p>The programme is planned with the residents having input through the resident meetings and on a one to one basis. The activities programme is displayed on a weekly planner with individual assessments documented when the interRAI assessments are completed. There are plans documented. Documentation of progress against plans are completed weekly and attendance records are maintained. Health care assistants also support activities when the activities coordinator is not present. Assessments</p>

		<p>and plans with evidence of review were sighted in all resident files reviewed.</p> <p>Regular exercises are provided and the programme includes intellectual activities, spiritual activities, input from external agencies and supported ordinary unplanned/spontaneous activities including celebrations. The programme is implemented ensuring the strengths, skills and interests of residents are maintained. Residents report they are happy with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>The residents' files sampled confirmed long-term care plans have been completed every six months as required. Clinical reviews are documented in the resident records, which include input from the general practitioner; registered nurse; clinical manager; health care assistant; the activities coordinator and other members of the allied health team.</p> <p>Daily progress notes are completed by the care staff at the end of each shift and at least every three days by the clinical manager or registered nurse. Progress notes reflect daily response to interventions and treatments. Residents are assisted in working towards goals. Short-term care plans are developed for acute problems for example: infections; wounds; falls and other short-term conditions. Short-term care plans have not been reviewed at regular intervals and an improvement is required.</p> <p>Additional reviews include the three-monthly medication and clinical reviews by the general practitioner.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility. There have been no building modifications since the last audit however there is continued refurbishment of the interior.</p> <p>A planned maintenance schedule is implemented and the maintenance staff and documentation confirmed implementation of this.</p> <p>There is a lift between the ground and lower floors with a current certificate of compliance in place.</p> <p>Areas in use have lounge areas that are designed so that space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids. There are quiet areas for residents to sit.</p> <p>Equipment relevant to care needs is available and staff confirm that there is always sufficient. A test and tag programme is in place. Equipment is calibrated.</p> <p>There are safe external areas for residents and family to meet/use and these include paths, seating and shade.</p>

<p><b>Standard 3.5: Surveillance</b></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>	FA	<p>The clinical manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated monthly. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.</p> <p>The infection control surveillance register includes monthly infection logs and antibiotic use. Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the quality meetings.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 is a job description for the position of the restraint coordinator. The service has no restraints and no enablers in use on audit day.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	There is a business plan documented however review of this is only partially documented as related to the potential growth of the business. The manager is in the process of documenting the quality plan as part of the business plan.	The business plan is partially reviewed. The quality plan is not fully documented.	<p>Review the business plan. Document and implement the quality plan with regular reviews documented.</p> <p>180 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	The required reference checks were not sighted in all staff files sampled.	Not all new staff have a documented reference check/s.	Ensure that all new staff have reference checks completed.

				180 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	There is a process documented around completion of performance appraisals. The manager is reviewing the template for documentation of the review. The manager is beginning to work towards completing all performance appraisals with a schedule set and implemented; however performance appraisals are yet to be completed for all staff as required.	Not all staff have had an annual performance appraisal.	<p>Ensure that all staff have an annual performance appraisal.</p> <p>90 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Low	Two staff signatures are recorded when signing out a controlled drug in the controlled drug register; however two signatures were not consistently recorded on the administration sheet when administering controlled drugs.	Two staff signatures were not consistently evident on the administration records when administering controlled drugs.	<p>Ensure two staff signatures are documented for the administration of controlled drugs</p> <p>90 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	The head cook has completed food safety training. Other cooks are required to complete training.	Three cooks have not completed food safety training.	<p>Provide training around food safety for all cooks.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	Short-term care plans are documented for a range of short-term conditions. There is reference to review of the plans in the progress notes however evaluation of the plans is not documented on the short-term plans at regular intervals.	Evaluation of the short-term care plan is not well documented.	<p>Document evaluation of the short-term care plan at regular intervals.</p> <p>180 days</p>



## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.