# Castlewood Nursing Home Limited - Castlewood Nursing Home

## Introduction

This report records the results of a Certification 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:** Castlewood Nursing Home Limited

**Premises audited:** Castlewood Nursing Home

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

**Dates of audit:** Start date: 14 November 2017 End date: 15 November 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:** 19

# 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

Castlewood Nursing Home provides rest home level care for up to 24 residents. Occupancy on the first day of audit was at 19 residents. This certification audit was 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, residents and staff files, observations and interviews with residents, family, management, general practitioner and staff

The manager is also the owner and responsible for the overall management of the facility. Clinical support and oversight is provided by two registered nurses.

There are twelve corrective actions required in organisational management across governance, quality and risk management, human resources and service provider availability.

## 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. |

Staff are able to demonstrate an understanding of residents' rights. This knowledge is incorporated into their daily work duties and caring for the residents.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices relating to the care they receive. Linkages with family and the community are encouraged and maintained. The service has a documented and implemented complaints management system.

Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The organisation's mission statement and vision is documented. There are processes in place for incident/accident management. The registered nurses collect data, evaluate and monitor key components of clinical care and share results among staff. Staff confirmed they receive training.

Staffing levels meet occupancy and acuity levels and residents state they have adequate access to staff when needed. Duty rosters sighted confirm that there is adequate staff available and staff confirmed they are aware of the process to assure safe staffing afterhours.

Adverse events are documented and discussed with residents and/or their family. The manager understands their statutory obligations regarding essential notification.

Resident record entries are legible with dates, signatures and staff designations included. All individual resident records are integrated and stored securely.

## 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. |  | Standards applicable to this service fully attained. |

Access to the facility is appropriate with relevant information provided to the potential resident/family by the registered nurses. The registered nurses and the residents’ general practitioner, assess residents’ needs on admission. Care plans are individualised, based on a range of information, and accommodate any new problems that might arise. Records reviewed demonstrated the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services if required.

The planned activity programme provides residents with a variety of individual and group activities and maintain their links with family/whānau and the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with any special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## 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 maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Fixtures, fittings, and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Hazardous substances are managed appropriately.

Essential emergency and security systems are in place with six monthly fire drills completed. Call bells enable residents to access help when needed.

## 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 organisation has implemented policies and procedures that support the minimisation of restraint. No enablers or restraints were in use at the time of audit. Use of enablers is voluntary, for the safety of residents and in response to individual requests. Staff stated restraint education is provided at orientation and is ongoing. Staff interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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 prevention and control programme led by a registered nurse aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by policies and procedures. Staff stated they have access to infection prevention and control education.

Aged care specific infection surveillance is undertaken, and results are fed back to staff. Follow-up action is taken as and when required.

## 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 | 41 | 0 | 1 | 3 | 0 | 0 |
| **Criteria** | 0 | 81 | 0 | 5 | 7 | 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 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Residents confirmed that they receive services that meet their needs and they receive information relative to their needs. Staff state they receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through in house training. Staff confirmed their understanding of the Code (refer to 1.2.7.5).  The auditors noted a respectful approach towards residents on the days of the audit. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There is an informed consent policy and procedure (refer 1.2.3.4) to direct staff in relation to gathering of informed consent. Resident files identified informed consent is obtained. Interviews with staff confirmed their understanding of informed consent processes. Staff ensure all residents are aware of treatment and interventions planned for them and the resident and/or significant others are included in the planning of that care.  The service information pack includes information regarding informed consent. The RNs discuss informed consent processes with residents and their families during the admission process. The policy and procedure includes guidelines for consent for resuscitation/advance directives (refer 1.2.3.4). Resuscitation orders are completed for residents when applicable. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Resident information relating to advocacy services is available at the entrance to the facility and in the information packs provided to residents and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time their complaint is acknowledged. Staff interviews stated they have received training (refer 1.2.7.5).  Family and residents confirmed the service provides opportunities for the family/EPOA to be involved in decisions and that they are informed about advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy and residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families confirmed they could visit at any time and are always made to feel welcome.  Residents are encouraged to be involved in community activities and to maintain family and friend networks. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The services complaints policy and procedures (refer 1.2.3.4) are in line with the Code and include timeframes for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved.  Evidence relating to each logged complaint is held in the complaints folder and register. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner. Staff, residents and family confirmed they are aware of the complaints process.  The manager is responsible for complaints management and residents and family stated that these are dealt with as soon as they are identified. Residents and family members were able to describe their rights and advocacy services, particularly in relation to the complaints process.  There has been one complaint lodged with the Southland District Health Board which had been closed out. There have been no complaints lodged with the Health and Disability Commissioner or any other external authorities since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The registered nurses (RN) discuss the Code with residents and their family on admission.  Resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. The Code of Rights posters identifying residents’ rights and advocacy services information is displayed in the facility. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Castlewood Nursing Home has a philosophy that promotes dignity, respect and quality of life. The service ensures that each resident has the right to privacy and dignity. The residents’ personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room and there are areas in the facility which can be used for private meetings.  Resident files reviewed confirmed that cultural and/or spiritual values and individual preferences are identified.  Healthcare assistants report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families confirmed that residents’ privacy is respected.  The service has a neglect and abuse policy, however, the policy does not inform staff of the procedure should abuse/neglect be suspected and/or identified (refer 1.2.3.3 and 1.2.3.4). There were no documented incidents of abuse or neglect in the incidents reviewed in the residents’ files. Residents, staff, family and the general practitioner (GP) confirmed there was no evidence of abuse or neglect. Staff confirmed they are aware of the need to ensure residents are not exploited, neglected or abused. Staff can describe the process for escalating any issues. Staff interviews confirmed that there has been training on abuse and neglect (refer to 1.2.7.5). |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The organisation has a cultural responsiveness policy which outlines the processes for working with people from other cultures. A Māori health plan (refer 1.2.3.4) outlines how to work with Māori and the relevance of the Treaty of Waitangi. There were no residents or staff who identified as Māori at the time of audit.  A review of residents’ files confirmed that specific cultural needs are identified in the residents’ care plans and interRAI assessments. The RNs access the Ministry of Health web site and Uruuruwhenua Health to guide practice. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents and family are involved in the assessment and the care planning processes. Staff and resident interviews confirmed there are choices for residents regarding their care and services. Information gathered during assessment includes the resident’s cultural values and beliefs. The initial care plan and the long-term care plan are based on this assessment information and incudes InterRAI assessment information. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Castlewood Nursing Home consumer policies and procedures are based on good practice, current legislation and guidelines, with multiple versions in differing formats which were made available on audit for review (refer to 1.2.3.4). On interview, staff stated orientation and induction includes recognition of discrimination, abuse and neglect, the staff code of conduct and prevention of inappropriate care, however, there was no documented evidence to confirm training has occurred (refer to 1.2.7.5).  Interviews confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination.  Job descriptions outline the responsibilities of position, including ethical issues relevant to the role (refer 1.2.7.2). Staff confirmed understanding of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Staff can describe good practice based on policies and procedures, care plans and information given to them via the registered nurses and the general practitioner (GP).  Consultation is also available with health professionals and specialists in the region. Staff are able to describe how and when they would make contact. Residents and families interviewed expressed satisfaction with the care delivered.  The medical centre is located next door to the facility and staff state they can access the GP when support is required. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Procedures guide staff on the process to ensure full and frank open disclosure is available. Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/EPOA of any accident/incident that occurs. Family stated they are informed if the resident has an incident/accident, has a change in health or a change in needs, evidenced in completed accident/incident forms reviewed. Family confirmed they are invited to the care planning meetings for their family member and can attend the residents’ meetings. Families confirmed they are well informed. Family contact is recorded in residents’ files.  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. The admission agreements reviewed were signed on the day of admission.  There is no policy or procedure in place to guide staff if interpreters are required (refer 1.2.3.3), however, staff confirmed that interpreting services are available from the district health board. There were no residents requiring interpreting services at the time of the audit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Moderate | Castlewood Nursing Home has a documented mission statement in the governance document, with generalised statements without clear direction or key performance measures for monitoring and review.  The manager is a registered mental health nurse without a current practising certificate. The manager has not completed any management training in the last 12 months and does not have a signed contract or job description (refer 1.2.7.5). There are two registered nurses who job share. The RNs have been in their roles approximately two years and both have current practicing certificates. One of the registered nurses has a theatre nurse background and the second RN has a background in intensive care nursing.  There are monthly staff meetings which include clinical quality and risk management in some clinical areas. These reports are instigated by the RNs, without management oversight (refer to 1.2.3.1).  Castlewood Nursing Home has contracts with the Southland District Heath Board (SDHB) for rest home services and aged related residential respite care. The facility can provide care for up to 24 residents requiring rest home level of care, with 19 rest home residents in the service on the days of the audit. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the owner manager, one of the two RNs are designated to the position of acting manager. One of the registered nurses recently covered when the manager was away for five weeks. |
| 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. | PA Moderate | There is a current quality and risk framework and limited risk register documented, however a number of gaps were identified in its implementation and understanding of this at a management level.  Service delivery is monitored through review of complaints, review of incidents and accidents with monthly analysis of data, completed by the RNs, however this is not reported through to management and there is no evidence that this information explicitly links to the quality management system.  The service has organisational policies and procedures to support service delivery, however not all required policies were in place or meet current legislative, health and disability standards or contractual requirements. There is no formal process in place for document control. Staff were able to articulate understanding and knowledge of policies in place, however, the manager was unable to demonstrate awareness of policies implemented and how to access current documents.  There are two monthly residents’ minuted meetings and families are invited to attend. There are monthly staff meetings with handwritten meeting notes, with no evidence of corrective actions being documented. There are informal monthly management meetings held with the manager and the RNs, however, there are no formal minutes documented for this meeting.  There is evidence of incidents, accidents and complaints being managed in a timely manner with relevant corrective actions reflected in the residents’ files where applicable. A current organisational audit schedule was not in place. There was evidence of nursing audits activity occurring in isolation. There was limited evidence of corrective action plans associated with any audit activity completed. There has not been a recent resident or staff survey completed.  There is no evidence of measurement of achievement against the quality management system. |
| 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 manager is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police attending the facility, sentinel events, infectious disease outbreaks and changes in key management roles. Evidence was sighted confirming that the Ministry of Health had been notified of the manager appointment.  Staff interviews and review of documentation evidence that staff document adverse, unplanned or untoward events on an accident/incident form which are signed off by the manager. There is a process which is implemented for neurological observations for head injuries when required.  There have been no deaths referred to the coroner. There has been one essential notification to Ministry of Health and the district health board since the last audit. |
| 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. | PA Low | Castlewood Nursing Home has documented human resource management policies and procedures. The skills and knowledge required for each position is documented in job descriptions with the exception of the manager. These were reviewed on staff files along with employment agreements (also with the exception of the manager), reference checks, copies of current practicing certificates, police vetting and completed orientations. There was no evidence of annual practicing certificates for the contractors that require them to practise, including the pharmacist.  The service has scheduled monthly in-service training as part of the monthly staff meetings as evidenced in meeting notes. There was no documentation to verify the in-service training content. The two RNs have completed interRAI assessments training and competencies. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.  An orientation/induction programme is available and new staff are required to demonstrate competency on a number of tasks, including personal cares. The staff orientation covers the essential components of the service provided. Healthcare assistants confirmed their involvement in supporting and buddying new staff.  Annual competencies are required to be completed by clinical staff. There was evidence in the clinical staff files reviewed of competencies completed for all staff. . |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | The staffing policy and rationale (dated 2003) does not reflect the aged residential contract and the health and disability standard (refer 1.2.3.3 and 1.2.3.4). In practice, staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix. Staffing levels are adjusted as required due to changes in acuity and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy. On review of rosters, adequate cover was evidenced with the exception of the diversional therapist (DT). The RNs job share and cover Monday to Friday. There are two staff members on duty in the facility on morning and afternoon shifts (i.e. either two health care assistants (HCAs) or a RN and a HCA). There is one HCA staff member on duty at night. Review of the rosters identified that the manager was roistered on two morning shifts per week for two consecutive weeks. There was no evidence to verify that the manager has completed competencies appropriate to the role of HCA.  There are 13 staff, including the manager, clinical staff, a diversional therapist, and household staff. The manager lives on site and is the first on call contact (refer 1.2.1.3).  There is no formalised process or policy for on-call management. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are policies and procedures in place for privacy and confidentiality of residents’ records. Relevant resident care documentation can be accessed in a timely manner. The service retains relevant and appropriate information to identify residents and track records. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Archived records are securely stored and easily retrievable.  All components of the residents’ records reviewed include the residents’ unique identifiers. The clinical records are integrated and include information such as medical notes, assessment information and reports from other health professionals. Medication charts are kept separate from residents’ files. Resident files and medication charts are accessed by authorised personnel only.  Residents’ progress notes are completed on every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes identify the name and designation of the person making the entry. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks current information from the NASC service or the GP for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Resident records reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and coordinated manner, with an escort as appropriate. The service uses the DHB ‘yellow envelope’ system to facilitate transfer of residents to and from acute services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress records. |
| 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 medication management policy is current (reviewed April 2017) and identifies all aspects of medicine management.  A safe process for administration of medicines was observed on the day of the audit. The staff member observed demonstrated a safe procedure and had a clear understanding of the role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs check medications against the prescriptions when delivered from the pharmacy. All medications sighted were within current use by dates. The clinical pharmacist input is provided six monthly including a medicine audit and medication records being reviewed (refer to 1.2.7.2).  The record of temperatures for the medicine fridge are within the recommended range.  Safe prescribing practices noted included the prescriber’s signature and data recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines being met. The required three monthly GP reviews are recorded on the medicine records. There is a current standing orders sheet in each individual resident’s medication record which are reviewed by their GP annually.  There is one resident who was self-administering medication at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.  There is an implemented process for evaluation analysis of any medication errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by an experienced cook five days a week. The cook’s days off are covered by the manager who has a certificate in safe food handling. The manager is currently advertising for a second cook. Staff who work in the kitchen have completed safe food handling and hygiene requirements. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and food temperatures are monitored and recorded. Most food is purchased locally. Other food stuffs are ordered by the cook or the manager and are delivered on a regular basis.  A nutritional assessment is undertaken by the RN for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily menu plan.  Evidence of resident satisfaction with meals is verified in the resident meeting minutes and resident/family interviews. Residents were seen to be given sufficient time to eat their meal in the dining room and those requiring assistance had this provided. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received and the prospective resident does not meet the entry criteria or there is currently no vacancies, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and the services offered are no longer suitable, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a cause in the resident agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools, for example, falls risk assessments; skin integrity; nutritional screening and continence assessments, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of the two trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the care plans reviewed.  Care plans evidence service integration with progress records, activities records, and medical notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents’ individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed and care is appropriately provided. Care staff confirmed that care was provided as outlined in documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| 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 activities programme is provided by a qualified diversional therapist (DT). A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated as part of the formal six monthly care plan review.  Activities reflect resident’s goals, ordinary patterns of life and include community activities. Individual and group activities and regular events are offered. Residents and families/whānau are involved in evaluation and improving the programme through residents’ meetings held two monthly. Residents interviewed confirmed they find the programme interesting. The DT interviewed had recently been on leave for three weeks and was not covered on the roster. Care staff ensured the resident’s enjoyed some organised activities (refer to 1.2.8.1). The sighted activities programme evidenced flexibility and incorporation of residents’ interests. The DT documented residents’ voluntary attendance at the sessions provided. A community van is available, able to be shared with other services in the community for outings and used for taking residents to appointments as required. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents care is evaluated on each shift and reported in the progress records. If any change is noted, it is reported to a RN.  Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessments, or when a residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted, for example, post falls, wound care and/or for infections such as urinary infections. When necessary, and for unresolved problems, long-term care plans are added to and updated accordingly. Residents and family members interviewed provided examples of their involvement in evaluations of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Residents may choose to use a medical practitioner of their choice. If the need for other non-urgent services is indicated or requested, the GP sends a referral to seek specialist input as required. Copies of referrals were sighted in residents’ records reviewed including but not limited to, orthopaedic; wound care nurse specialist; physiotherapist and podiatrist referrals. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency at the rural hospital in an ambulance, if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Material safety data sheets are available throughout the facility and accessible to staff. Staff receive training and education in safe and appropriate handling of waste and hazardous substances (refer 1.2.7.5).  There is provision and availability of protective clothing and equipment that is appropriate for the recognized risks within the facility. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas. Chemicals are securely stored in a designated cupboard. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed. There have been no building modifications since the last audit.  There is a planned and reactive maintenance schedule implemented. The service has an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually. Interviews with staff and observation of the facility confirmed there is adequate equipment.  There are quiet areas throughout the facility for residents. The external areas are maintained and appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken. Residents confirm they are able to move freely in and around the facility and that the accommodation meets their needs. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible communal toilets/bathing facilities. There is a visitor/staff toilet. Communal toilet facilities have a system that indicates if it is engaged or vacant. Some rooms have shared en-suites.  Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence where required. Residents and family members interviewed reported there are sufficient toilets and showers. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All bedrooms have sufficient space for residents to mobilise with or without assistance in a safe manner. Rooms can be individualised with furnishings, photos and other adornments and the service encourages residents to make the room their own. Residents spoke positively about their rooms and rooms were observed to be personalised.  There is room to store mobility aids such as walking frames in the bedroom safely during the day and night, if required. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has a lounge/dining area that is also used for activities. Residents can choose to have their meals in their room or in the lounge/dining room. Residents are able to access areas for privacy, if required. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The service has procedures in place for cleaning, with staff able to describe how they complete cleaning tasks. There is a dedicated locked storage area for cleaning equipment and chemicals. Staff state that there is training on the use of products and staff are reminded to keep the trolley with them at all times. Cleaning is monitored by the owner. The facility was observed to be clean on the days of audit.  All laundry, including residents’ personal laundry is completed on site with a dirty and clean process in place.  Staff and residents interviewed confirm they always have enough linen to meet day-to-day needs. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved evacuation scheme in place.  Emergency management policies and procedures guide staff actions in the event of an emergency (refer 1.2.3.4). Emergency plans take into account emergency systems such as: fire protection equipment; emergency lighting; and communication. Fire equipment is checked monthly by an approved provider. All resident areas have smoke alarms and a sprinkler system. Emergency education and training for staff includes six monthly trial evacuations and there is always a staff member on duty with a current first aid qualification.  Emergency supplies and equipment include food and water. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas barbeque that can be used for cooking.  Appropriate security systems are in place with staff checking that the premises are secure at night. Staff and residents confirm they feel safe at all times. Call bells are located in all resident areas. Resident and family/whānau confirmed call bells are answered within an acceptable timeframe. Call bells and sensor mats checked on the day of the audit are functional and calls responded to in a timely manner. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.  Family and residents state that the building is maintained at an appropriate temperature in both winter and summer. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from the two RNs and a GP, if required. The infection prevention and control programme and manual is reviewed annually.  One of the two RNs is the designated infection control coordinator with their role and responsibilities defined in a job description. Infection control matters, including surveillance results, are reported monthly at the staff quality meeting. The RNs, the cook, the cleaner and care staff make up the infection committee.  Infection control signage is displayed at the entrance to the rest home and people who have been unwell are encouraged not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood their responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for over two years. The infection control coordinator has undertaken online learning in infection prevention and control and has attended courses/training, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, a local rural hospital, the community laboratory, the GP and public health, as required. The infection control coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The infection control coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There have been no outbreaks of infection since the previous audit. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted practice. Policies were last reviewed October 2017 and include appropriate referencing. Care delivery, cleaning/laundry and kitchen staff were observed following organisational policies, such as: appropriate use of hand sanitisers; good hand washing technique; use of disposable aprons; gloves and hats. Hand washing and sanitiser dispensers are readily available around the rest home and paper hand towels were evident in all individual resident rooms and all service areas. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observations and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the RNs at handover between shifts, during the staff monthly meetings or at bedsides, if required. Records are maintained by the infection control coordinator of infection control topics covered. Education with residents is generally on a one-to-one basis and has included hand washing, advice about remaining in their room if unwell and increasing fluids, as required. |
| 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 | Surveillance is appropriate to that recommended for long-term care facilities. The infection control coordinator reviews all reported infections and these are documented. New infections and any required management plan is discussed at handover to ensure early intervention occurs.  Monthly surveillance data is collated, analysed and graphs are developed to identify any trends, possible causative factors and required actions. Results of surveillance are shared with staff via the staff monthly meetings and at staff handovers (refer 1.2.3.5). Graphs are produced that identify trends for the month and current year and comparisons against previous years can be viewed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the required needs of the restraint minimisation and safe practice standards and provide guidance for staff on the safe use of both restraints and enablers. One of the RNs is the restraint coordinator. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated an understanding of the role and responsibilities in interview. On the day of the audit, no residents were using restraints or enablers. Staff interviewed reported education was provided and this was evidenced in the training records reviewed. Staff understood the restraint/enabler process. |

# 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 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | There is a current overarching governance document which was reviewed August 2017. The governance document outlines generic goal statements, without reference to timeframes and responsibilities and references out dated information relevant to the previous manager, in the business plan section of the document (refer to 1.2.3.4). | The governance document does not have key performance measures, timeframes and who is responsible and is not reflective of the current management structure. | Ensure the governance document is current and reflects a planned, coordinated approach to services provided, including key performance measures which are regularly reviewed.  180 days |
| Criterion 1.2.1.3  The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services. | PA Moderate | The manager has owned the business since 1999 and lives on site. Historically there has been an appointed clinical manager who resigned 14 months ago and the owner has been self-appointed to the role of manager of the service. There is no evidence of management qualifications or of eight hours professional development being completed annually appropriate to the role. | The manager has not completed the required management training as per the aged residential care contract. | Ensure the manager completes relevant education to meet the aged residential care contract.  90 days |
| Criterion 1.2.3.1  The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Moderate | There is a current documented quality and risk management system, however it does not include objectives for improvement, accountabilities, timeframes or review to support and guide quality and risk management. On interview, the manager was unable to articulate or demonstrate how the quality and risk management framework was implemented or aligned with the quality framework documented. Some aspects of quality and risk processes being implemented in some clinical areas by the two RNs in isolation without management oversight. There is no evidence of overarching organisational quality and risk management, monitoring, analysis, mitigation and reporting. | The quality and risk management system is ad-hoc with no evidence of overarching monitoring or reporting at a management level of the organisation. | Ensure a quality and risk management framework is implemented with management oversight appropriate for the size and nature of the aged care service.  90 days |
| Criterion 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | There are polices in place to guide practice, however, there is no process to ensure policies are aligned with current good practice and meet legislative requirements. Not all policies have been reviewed in a timely manner. There are policies which do not have procedures and processes to guide staff (e.g. abuse and neglect) and some policies are not documented, (e.g. interpreter policy). | i) There is no formalised process in place to ensure that policies and procedures align with good practice, meet legislative requirements or are reviewed in a timely manner.  ii) The abuse and /or neglect of resident’s policy does not describe the procedure should abuse and /or neglect be suspected or identified.  ii) There is no interpreter policy available to guide staff. | i) Ensure a process is implemented to review policies in a timely manner to assure their currency and alignment with good practice and legislation.  ii) Document a procedure to effectively manage any incidence of abuse and /or neglect.  iii) Document an interpreter policy which includes the process to access interpreters and maintain current information on interpreter services available.  180 days |
| Criterion 1.2.3.4  There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. | PA Low | There are policies in place, however, not all policies provided for review were current. There was evidence of multiple versions and differing formats of policies for the same purpose in circulation at the time of the audit. | There is no document control system in place to ensure version control of policies. | Ensure a document control process is written and implemented.  180 days |
| Criterion 1.2.3.5  Key components of service delivery shall be explicitly linked to the quality management system. | PA Moderate | The RNs are collecting, analysing and evaluating clinical data, and reporting this information formally back to staff during meetings. This includes the outcomes and the corrective actions that are required to improve health outcomes. There is no evidence of how this information is linked to an overarching quality management system. | There is no process to link key components of service delivery to the quality and risk framework. | Ensure a process is documented and implemented to link the key components of service delivery to a quality and risk framework.  90 days |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Moderate | The service has some nursing directed quality audits occurring, however these are not reported to management as part of the overall quality and risk management framework. As there is no overarching quality and risk management system implemented, with specified timeframes, clear objectives and responsibilities, there is no ability to measure achievement against the quality and risk management plan. | There is no clear process documented to monitor and measure achievement against the quality and risk management system. | Ensure a quality and risk management system is implemented with clear processes to measure quality against.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Incidents/accidents, nursing audits and complaints are completed with corrective actions in place. Meeting minutes completed do not have corrective action plans. There is no planned current organisation audit schedule in place and there has been no recent resident or staff survey completed to support quality improvement processes, inclusive of corrective action management. | i) Areas requiring improvement are not always identified.  ii) Corrective action plans are not always developed or closed out. | Ensure a process is implemented to identify, document and close out corrective action plans.  90 days |
| Criterion 1.2.3.9  Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Moderate | The service has a hazard register in place to identify facility issues, which are completed in an ad-hoc manner by the manager. There is a current documented risk management framework within the quality and risk management system, with a limited risk register documented, however there was no evidence of an active implementation process to identify, monitor and mitigate risk. | There is no evidence of an implemented process to identify, monitor and mitigate risk. | Ensure a process to identify, manage and mitigate risk is documented and implemented..  90 days |
| Criterion 1.2.7.2  Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Low | The two RNs have current annual practising certificates, however, there was no evidence in the staff files of current practising certificates for allied staff or contractors such as the pharmacist. The manager was self-appointed and does not have a current relevant job description for the role. | i) There was no evidence of current annual practising certificates or pharmacy licence verification for the contracted staff.  ii) The manager does not have a current relevant position description. | i) Ensure a record of all annual practising certificates for contracted staff are maintained on staff files.  ii) Ensure current and relevant position descriptions are in place for all staff.  180 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is a monthly in-service training that is incorporated in the staff monthly meetings. Staff confirmed that in-service training was attended, however there was no evidence the training was provided by an appropriately qualified person or documentation to evidence the content of the training provided. | There was no evidence of the content of in-service training held. | Ensure in-service training content meets service requirements and is provided by appropriately qualified staff.  180 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | Residents and families stated staffing is adequate to meet the residents’ needs. Interviews with RNs confirmed there is an informal agreement for staff to call them for clinical advice.  There is no formalised process or policy for on-call management. A consultation document (dated August 2016) to the RNs in relation to payment for afterhours work, specifies that Castlewood Nursing Home does not request on-call services from its employed nurses. The manager is the first person to be called after-hours. The RNs are not on an on-call roster. | There is no formal documented policy or process to reflect safe staffing management for the aged residential care contract or standard obligations with regard to:  i) Skill mix  ii) Acuity levels;  iii) Escalation planning;  iv) On call arrangements  v) Leave cover for the diversional therapist. | Ensure a process is documented to formalise safe staffing management that meets all requirements.  90 days |

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

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

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

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

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End of the report.