# Edenvale Trust Board

## 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 Q-Audit 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:** Edenvale Trust Board

**Premises audited:** Edenvale Rest Home

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

**Dates of audit:** Start date: 23 November 2017 End date: 23 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:** 41

# 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

Edenvale Rest Home is owned and governed by a board of trustees. The management of the home is overseen by the general manager (GM). The rest home provides care for up to 45 residents. There were 41 residents on the day of the audit. Three levels of care are provided - rest home, secure dementia care and hospital level care. In December 2015 the home received reconfiguration authority from the Ministry of Health (MOH) to increase their rest home capacity from 29 beds to 33, taking their total capacity from 41 to 45 beds.

This surveillance audit was conducted in accordance with the relevant Health and Disability Standards and the contract with the district health board (DHB). The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff, management and a general practitioner. Two family members were available to be interviewed by telephone on the day of the audit.

The organisation has addressed the corrective action raised during the previous audit and no areas for improvement were identified during this audit. The organisation maintains the continuous improvement rating around their quality and risk management programme.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Residents and family are well informed, including of changes in resident’s health, this was well documented in the clinical records. Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs. Learning’s from complaints are used to develop improvements and a complaints register is maintained. Interpreter services are available if required and staff are from diverse cultural backgrounds and are able to interpret for residents if needed.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The GM develops an annual business plan which sets out the direction of the company for the following year. The plan is approved by the board of trustees. The GM reports on all areas of the business to the board and is supported by the clinical manager and the administration manager.

A well-established quality and risk management programme is fully embedded in all aspects of the organisation. Staff are engaged in quality improvements and quality data is reported to the Quality & Risk Management (QRM) meetings. Adverse event reporting captures all incidents and accidents. Near miss events are reported through the health and safety system. A framework for internal auditing is used and this has been further developed since the last audit. Improvement plans are developed and corrective action taken to address service shortfalls.

The organisation implements good practice with regard to human resource management. Staff receive an orientation and ongoing training. . Staffing is sufficient to cover the care needs of residents at all times.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

Residents` needs are assessed by the multidisciplinary team on admission within the required timeframes. The clinical manager is supported by the registered nurses, care staff, allied health professionals and two designated general practitioners (GP’s). On call arrangements for support are in place. Shift handovers and a communication book is available to guide continuity of care.

Care plans are individualised based on a comprehensive and integrated range of clinical information. Short term care plans are developed and implemented to manage any new problems that might arise. All residents` records sampled demonstrated that need, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The activities programme provides residents with a variety of individual and group activities and maintains the residents` links with family and the community. Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless and are available 24 hours a days.

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

The foodservice meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents/families verified satisfaction with meals provided.

## Safe and appropriate environment

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

There has been a small addition made to the dementia area since the last audit. The lounge has been extended into the garden and now provides a larger area for residents to wander. This resulted in a minor change to the fire evacuation plan, with has been approved. There have been no other changes. There is a current building warrant of fitness and fire drills are held six monthly as part of the health and safety programme. The physical environment promotes safe mobility and aids independence.

## Restraint minimisation and safe practice

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

The organisation implements policies and procedures that support the minimisation of restraint. No enablers or restraints were in use at the time of the audit. Use of enablers when used is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of restraint and enabler processes.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The rest home has an appropriate infection prevention and control management programme this is resourced to include collection and collation of surveillance data and benchmarking occurs against previous periods of internal data. Infection prevention activity is evident in the actions of care giving and potential outbreak identification is well understood. The facility has not had an outbreak since the last audit.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 40 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a current complaints policy. The policy is included in every admission pack and printed on the back of the complaints forms which are available in the lounge. The GM manages all complaints. Once a complaint is received it is logged in the register which identifies the nature of the complaint and the follow up action taken. Complaints are reported at staff meetings and to the quality and risk meetings. There was evidence that complaints are used to identify areas that can be improved  Residents and family (where appropriate) are informed of the outcome of complaints investigations. Residents interviewed confirmed their knowledge of, and access to, the complaints process.  It was reported by the GM that there have been no complaints or investigations by the Ministry of Health (MoH), Health and Disability Commissioner, District Health Board (DHB) or Accident Compensation Corporation (ACC) since the previous audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a clear process for informing families of incidents or accidents. Records of adverse events sampled confirmed that families are informed in a timely manner. There is an interpreter policy and staff are aware of how to access interpreters if required. There are a number of staff from a variety of cultures who are able to communicate with residents where English is a second language. Uniforms and name badges are worn to identify staff.  The rest home uses the New Zealand Aged Care Association Resident Agreement. This provides the residents’ with appropriate information regarding the services they are to receive.  Family meetings are held within six weeks of a resident moving in and then on a minimum of annually going forward. The GM and clinical manager reported that they are available to talk to residents and family members as required. This was confirmed by residents interviewed.  Resident meetings are conducted every six weeks. Records of resident meetings confirmed good communication between management, staff and residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The rest home is owned and governed by a board of trustees. The GM is the board secretary and writes the annual business plan which is signed off by the board at the beginning of each calendar year. The 2017 business plan was sighted. This sets out the strategy for the organisation. The board has a trust deed which is underpinned by Christian values. The organisation has a philosophy documented in the purpose and objective statement updated in June 2017. The annual plan is reported against at each board meeting. This was confirmed in the board report sampled.  The GM is responsible for the day to day running of the home and has been in the role for over 17 years, and in management for over 20 years. The GM has a current contract with the board and detailed job description. The clinical manager is a register nurse and supports the GM. The GM is also supported by the administration manager. There is a delegation of authority that defines these roles. The GM keeps skills current through membership of appropriate organisations and attendance of relevant courses. Records of on-going education for the GM were sighted. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has an established quality and risk system that is embedded into practice. Quality data is collected across all levels of the organisation the Committee Structure and Function Procedure sets out committees and reporting structures for the organisation. Quality related information is reported to the quality risk meetings (QRM).  QRM meetings are held monthly, monitoring, collation and evaluation of quality and risk data is comprehensive. Quality and risk data, including trends in data and benchmarked results are discussed in the meetings and were evident in meeting minutes sampled. There is evidence of staff involvement in quality and risk management processes  An annual internal audit schedule was sighted. As part of ongoing improvements an additional spot audit process has been developed and implemented. There is evidence of internal audits occurring as per the audit schedule. Corrective actions are established, implemented and are signed off when completed. The continuous improvement issued at the last audit (refer criterion 1.2.3.7) remains.  Residents are asked to complete an annual satisfaction survey and asked monthly at their meetings if there are areas where improvements that can be made.  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are reviewed every two year (or sooner if legislative requirements change) and new policies, or changes to policy, are communicated to staff. Obsolete documents are removed from circulation. All documents are issued in hard copy.  There is a risk management system. Risks are identified and monitored. Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are implemented. Hazard identification forms and a hazard register are in place. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Adverse event reporting is understood and is reflected in policy. The GM confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. It was reported that there have been no adverse events, incidents or accidents which require reporting to external bodies since the previous audit.  There is a comprehensive accident and incident process and a register is maintained. Each accident and incident is reported and information is used to improve service. Incident reports were sampled and confirmed that family were contacted, investigation was undertaken, and that reporting to staff and quality meetings occurs. Appropriate changes and improvements were made when identified. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Policies and procedures identify human resource management that reflect good employment practice and meet the requirements of legislation.  Staff files sampled contained job descriptions, employment contracts, qualifications and competencies relevant to the role. Only staff that have dementia qualifications work in the dementia unit. Referee checks and police checks for New Zealand staff were sighted in staff files sampled. Employees who were not from New Zealand had these checks undertaken prior to employment. Professional qualifications are validated and current practising certificates for the registered nurses were sighted.  All staff receive an orientation to the organisation and to their role. There was an electronic education data base and this showed that staff had either completed, or were working their way through, the six orientation modules. Staff also undertake training that has been identified as required. Topics for the six modules included the essential components of service delivery and the organisations on-going education requirements under their contract with the district health board. Records of staff education are maintained.  Formal performance appraisals are undertaken every two years. Ongoing staff performance is monitored by the GM and clinical manager continually between the formal appraisals through a combination of several activities. For example the internal audits, ongoing observations and attendance at regular staff meetings. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The recently appointed clinical manager is responsible for the oversight of clinical services and there is always a registered nurse on site. Rosters sampled confirmed that there is a sufficient number of staff with the required skills and knowledge to ensure that all residents’ needs were met over the 24 hour period. In the event of an unplanned staff absence, the roster can be filled by another staff member or an agency staff member. The GM has a sound relationship with an agency and has agency nurses who know the home and residents to call on if required. There is also sufficient flexibility that if additional staff are needed due to increased work load that this can occur.  The quality initiative identified at the last audit regarding case management continues. This has been extended and now requires all registered nurses to complete the InterRAI requirements for the residents they case manage. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medicine management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles 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 registered nurses check the medications against the prescription against the prescription. All medication sighted were within current use by dates. Clinical pharmacist input is provided six monthly and on request.  The records of temperatures for the medication fridge was reviewed and remained within the recommended range.  Good prescribing practices noted included all dates when a medication is commenced, discontinuation of medicines as required are dated and all requirements for pro re nata (PRN) medicines are met. The required three monthly GP reviews are consistently recorded on the electronic medication records reviewed.  There were no residents who were self-administering medications 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 comprehensive analysis of any medication errors. An area identified for improvement at the previous audit in relation to crushing medication has been addressed. A guide for crushing oral medication for residents with swallowing difficulties has been adopted from a DHB and implemented. |
| 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 foodservice is provided on site by a contracted provider, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and daily menus are displayed in the dining rooms. The menu plans have been reviewed by a qualified dietitian in the last two years. The manager regularly discusses with the contracted service providers any food service issues/food and/or residents. The cook is responsible for all aspect of food procurement, production, preparation, storage, transportation, delivery and disposal and ensures all current legislative obligations are effectively met. The service is working towards the required food safety plan with the contracted service provider.  Food temperatures, including high risk items, are monitored appropriately and recorded as part of the plan. The cook and kitchen staff have completed safe food handling training. A nutritional assessment is undertaken for each individual 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 the kitchen staff and accommodated in the daily menu plan. Special equipment to meet resident`s nutritional needs is available.  The meal service was observed at lunchtime and all residents were enjoying their meals. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided by the staff in the dining room both in the dementia service and the rest home/hospital dining room. Snacks are available for all residents, including those in the dementia unit, between meals and over the 24 hour period. |
| 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, observation 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 range of resident`s individualised needs was evident. The general practitioner interviewed verified that they are contacted in a timely manner as required, that medical orders are followed, and care is provided. Care staff confirmed that care was provided as outlined in documentation. A range of equipment and resources was available which is 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 an activities coordinator who is currently enrolled in an activities training programme. The activities programme for this home is implemented Monday to Friday with staff providing activities as planned in the weekends. Activity plans for residents in the dementia unity cover the 24 hour period.  A full 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 six monthly as part of the formal six monthly care plan review process.  Activities reflect residents` goals, ordinary patterns of life and include normal community activities, individual group activities and regular events are offered. The programme is displayed on the notice board in the lounge, and staff room. Photo boards evidence social activities and all birthdays are celebrated. Music sessions, quiz sessions, church services, bowls and other activities are documented. There was a homely atmosphere throughout the home.  The feedback from staff and families about the programme was positive. Residents and families/whanau are involved in evaluating and improving the programme through separate resident`s and family meetings held three monthly and satisfaction surveys annually. Residents` interviewed enjoyed the programme and sessions provided. Bus trips are arranged into the community. Residents interviewed enjoyed the programme and resident/family/volunteer participation is encouraged by staff.  Activities for the residents in the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes card games, colouring in, one on one time with staff and other activities. Staff have access to activities resources available. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and is reported in the progress records. If any change is noted, it is reported to the registered nurses.  Formal care evaluations, occur every six months in conjunction with the six monthly interRAI reassessments, or as residents` needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. InterRAI assessments are currently fully completed for all residents. Examples of short term care plans being reviewed and progress evaluated as clinically indicated were noted for infections, wounds and residents being monitored for weight loss. When necessary, and for unresolved problems, long term care plans are updated. Residents and families provided examples of involvement in evaluation of progress and resulting changes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Building warrant of fitness expires on the 30th September 2018 and displayed in reception.  The minor extension to the dementia unit required the fire evacuation plan to be reviewed. The approved evacuation plan was sighted and fire drills are held six monthly as part of the health and safety programme.  The physical environment aids free movement from inside to out, the gardens provide a haven for the residents. Residents in the dementia area have a secure external area to wander. The environment promotes safe mobility, exampled by ramps from inside to out and areas of floor level change.  Plant and equipment requirements are managed through a plan maintenance programme. Testing and tagging of electrical equipment has been completed as required and all medical devises are calibrated as per manufactures instructions. |
| 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 | Policies and procedures reflect good practice and direct the infection control programme. This is appropriate to the size and setting of the service. Infection control rates were monitored, reported and managed. Specific recommendations and interventions are discussed at monthly staff meetings; antibiotic usage is monitored and measured. The clinical manager and staff manage infections through short term care plans and report as per process,.  Infection control is a standard agenda item for the QRM meetings and data is benchmarked against previous periods rates. The board is notified if there are any areas of concern. |
| 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. A registered nurse is the restraint coordinator. The coordinator provides support and oversight for enabler and restraint management and demonstrated an understanding of the organisation`s policies, procedures and practice. On the day of the audit, no residents were using restraints or enablers. Staff interviewed reported education is provided at orientation and is ongoing and they 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.

|  |
| --- |
| No data to display |

# 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | CI | The organisation continues to identify quality issues through its comprehensive quality systems and the review of qualitative and quantitative data. Improvements continue to be made including improved outcomes for residents.  An example of an outcome from the continued analysis of the quality data gathered is the addition of spot audits to the internal audit schedule. These are internal audits designed for specific areas such as the kitchen and laundry and have resulted in better service flow and time resource. This was confirmed in records of audits and interviews with staff.  A targeted improvement program has resulted in the building of a conservatory in the dementia ward. There was a concern from staff and families that the residents did not have adequate areas to wander which may have been impacting on residents’ behaviour. The renovation included an extension into the garden. This has allowed the residents to move freely inside and out and a review of adverse events demonstrates a decrease in behaviour incidents. | Continuation of the analysis of the results of internal audits has resulted in further quality initiatives which has improved work flow and residents outcomes. |

End of the report.