# Sandra MacLean - Lady Elizabeth Home and Hospital

## 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 The DAA Group 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:** Sandra MacLean

**Premises audited:** Lady Elizabeth Home and Hospital

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

**Dates of audit:** Start date: 25 September 2018 End date: 25 September 2018

**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:** 55

# 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

Lady Elizabeth Home and Hospital provides rest home and hospital level care for up to 55 residents. The service is operated privately by a registered nurse who is the owner/manager. She is supported by an office manager, kitchen manager, activities manager and a team of registered nurses. Residents and families spoke positively about the care provided.

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

There were no areas identified for improvement from this audit. There were no improvements to follow up from the previous audit.

A continuous improvement rating has been made in relation to the activities programme.

## 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. |

Residents and family reported that they are given sufficient information and feel informed. Management has an open-door policy. Information regarding the services available is provided and resident satisfaction surveys are conducted. There was evidence that family members are notified as required.

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

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

Business and quality and risk management plans include the scope, direction, goals, and values of the organisation. Monitoring of the services is overseen by the nurse/manager who works full time at the facility. The nurse/manager holds a current annual nursing practising certificate and has owned and operated the business for over 30 years. All staff holding senior roles are experienced and suitably qualified for the roles they undertake.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Long and short-term care plans are developed and evaluated in a timely manner. Interventions required are sufficiently detailed in the plans to address the care needs. Short term care plans are developed when acute conditions or issues are identified, and resolutions are documented.

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

The medicine management system meets the required legislative regulations and guidelines. Medication competencies are maintained annually.

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

## Safe and appropriate environment

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

There is a current building warrant of fitness.

## 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 a restraint free environment. No enablers or restraints were in use at the time of audit. Policy documents include a comprehensive assessment, approval and monitoring process which identify that regular reviews would occur for any resident who has restraint in place. Policy showed that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff 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. |

Infection control surveillance activities are appropriate for the size and nature of this service.

## 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** | 1 | 15 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 38 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.  The complaints register reviewed showed that one complaint had been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. The actions taken following the complaint showed that improvements were made to the cleaning services. The nurse/manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources 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 evidence of open and transparent communication between residents/relatives, staff and management. A review of adverse event confirmed timely and open communication with residents/family members. Communication with family members is recorded in the progress notes. Family members interviewed expressed satisfaction with how well they were kept informed about any change to the resident’s condition and their involvement in residents’ care planning. Residents’ meetings are held three monthly and minutes are recorded.  The owner/nurse manager advised that interpreter services are able to be accessed from the DHB interpreter services if and when required. This information is also provided to residents/families as part of the information/admission pack. |
| 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 quality systems, quality plan, strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of regular reviews of the plans by members of the senior management team with sign-off of completed items by the nurse/manager showed that adequate information monitoring performance is undertaken which includes financial performance, quality data trending, complaints management, infection control, falls, incident and accidents, environmental maintenance, restraint, emerging risks and issues.  The service is managed by the owner who is a registered nurse with a current annual nursing practising certificate and who holds relevant qualifications. She has been in the role for over 30 years. She is supported by an office manager, kitchen manager, activities manager and a team of eight registered nurses. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements. Members of the management team confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through regular on-going education and attendance at relevant age care conferences and seminars.  At the time of audit there were 38 hospital level and 17 rest home level care residents. The service holds contracts with Counties Manukau District Health Board (CMDHB) and the Ministry of Health (MoH) for younger persons, respite, complex medical conditions, rest home and hospital level care, including palliative care. The service also undertakes interim care for CMDHB orthopaedic services that do not use a contract for this service. The interim care is arranged with the facility on a case by case basis. There were no interim care residents at the facility at the time of audit.  Fifty-one residents were receiving services under the Age Residential Related Care contract and one under the Community Residential Respite contract (both with CMDHB). Three residents were receiving care under the MOH Residential Non-Aged contract at the time of audit.  There are six units located on the same site which are occupied by private renters. (They are not ORA contracted). |
| 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 a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey and monthly resident meetings, monitoring of outcomes, clinical incidents including infections and wounds, skin tears and pressure injuries.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting, health and safety/infection control meetings and staff meetings. Quality data is trended against previously collected data with a detailed three monthly review report documented. The report lists the objectives of the review, all corrective actions taken, the outcomes of the corrective actions and evaluation. Each report is signed off by the nurse/manager.  Staff reported their involvement in quality and risk management activities through audit activities, project involvement and implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. (Corrective actions are documented on planning sheets). Resident and family satisfaction surveys are completed throughout the year. Monthly staff meetings have a set agenda which provides evidence related to resident satisfaction of social activities, food, care, and maintenance. The 2018 survey results showed that residents and families were satisfied with all services. Residents also have an open forum during their monthly meetings where any issue can be raised.  Corrective actions are documented related to one complaint received. (Refer to standard 1.1.13). Audit outcomes are used to measure documented service objectives and any audit which had not gained a 100% rating showed the actions taken to improve services offered. For example, the resident clinical notes audit identified that daily entries could be improved to show more clearly how resident centred care was being delivered. Staff education was put in place in March 2018 and the audit was repeated to show that improvements had been made and a 100% compliance was gained. Staff verbalised this during interview as one of the quality improvements they valued.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The nurse/manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Senior members of the staff form the health and safety/infection control committee and all risks are monitored monthly. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. |
| 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 | Staff document adverse and near miss events on an accident/incident form. Non-resident related incidents are reported on an incident form. A sample of incident/accident forms and incident forms reviewed showed these were fully completed, incidents and accidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported the senior management team, at the two weekly registered nurses’ meetings (care team), and at staff meetings. The nurse/manager is informed daily of all incidents and accidents. Documentation identifies that family are kept well informed in a timely manner.  The nurse/manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no coroner’s inquests or issues-based audits. One police investigation occurred following a burglary of a staff member’s purse and this is now closed. An infectious outbreak was reported to public health in July 2017. All required documentation was sighted. |
| 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 | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and an annual performance review is undertaken by the nurse/manager.  Continuing education is planned on an annual basis, including mandatory training requirements. Mandatory training such as fire and emergency management attendance is monitored by the office manager. Monthly on-site education includes guest speakers such as a nurse practitioner for wound care, a continence specialist and a funeral director in relation to cultural aspects for palliative care. Off-site education includes hospice, first aid and DHB training days. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. The nurse/manager is the internal assessor for the programme. There is currently only one registered nurse who is trained and competent to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual competencies. Another interRAI trained staff member left the facility on the Friday prior to audit. The nurse/manager stated that more staff will be sent on the interRAI training in the near future. All interRAI assessment were up to date. (Refer comments in standard 1.3.3.) |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Staffing levels exceed the interRAI acuity level report findings. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All clinical staff hold current first aid certificates. There is 24 hour/seven days a week RN coverage at the facility.  Dedicated kitchen staff cover all meals seven days a week. The activities coordinator works five days a week. There are dedicated cleaning and laundry staff seven days a week.  Staffing numbers on all shifts allow for the care staff to respond to call bells from the six independent living units, occupied by private renter, which are on the same grounds as the care facility. The nurse/manager confirmed that there is always a registered nurse at the care facility and at night when a call bell is activated from the units a caregiver attends it. |
| 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 | A medicine management system is implemented that complies with current legislative requirements and safe practice guidelines. Policies and procedures are available to guide staff. Allergies and sensitivities are documented as well as necessary identifiers on the medical notes and the medication record. Medications prescribed are reviewed every three months by the general practitioner. An electronic system is implemented and the resident contracted general practitioner interviewed spoke highly of the benefits and the reduction in medication errors.  Weekly and six monthly controlled drugs stocktakes are conducted. The controlled drugs register was reviewed and was correct and current. A system is in place for returning expired or unwanted medications to the pharmacy. Al medications are securely stored. The pharmacist performs audits six monthly.  The registered nurse administered the lunchtime medications and this was observed and evidenced a safe medication administration process. Only one resident self-administrates an inhaler as needed. A process is in place and competency is reviewed and approved regularly.  The registered nurses and senior care staff complete annual medication competencies.  Temperature monitoring of medications is completed each afternoon and records are maintained. Medication trollies are locked and stored appropriately when not in use. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared and cooked on site. The cook is very experienced and has been the cook at this facility since 1995. The cook interviewed discussed the food service. There are four weekly menu plans which were audited 28 March 2018. The contracted dietitian has a current annual practising certificate which was sighted. The food service food safety plan was rated (A plus) grade 100% by Eatsafe. The issue date of the certificate was 02 August 2018 and this expires 02 July 2019. In addition to this, an internal meal/food survey was performed with resident and family involvement 30 March 2018. The survey evidenced that residents were satisfied with the meals provided.  Special diets, likes and dislikes can be catered for. A dietary profile is completed by a registered nurse for each individual resident on admission. A copy is retained in the resident’s record and a copy goes to the kitchen staff. Foodservice policies and procedures include principals of food safety, ordering, storage, cooking, reheating and food handling. A system is in place when receiving and utilising kitchen supplies. A kitchen cleaning schedule is implemented. Fridge/freezer/cooler and food temperatures are recorded daily.  The meals were well presented and the residents reported they are provided with an alternative meal on request. Residents are weighed routinely. Those with unexplained weight decreases are provided with food supplements or fortified meals where appropriate. The staff were observed feeding those residents that required assistance at the lunchtime meal. Referrals can be made directly to the dietitian if and when required. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | There are eight registered nurses not including the nurse manager. Resident lifestyle plans are developed by the registered nurses after the interRAI assessments are completed. Interventions are sufficiently detailed to address the desired goals/outcomes. Documented interventions are practical and care staff reported that care plans are easy to follow. Monitoring forms are in use as applicable, such as weight, vital signs, wounds and behaviour. Wound assessment, monitoring and wound management plans are in place as required. The nurse manager has access to specialist services as required. The general practitioner interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care provided is excellent. A range of equipment and resources was available suited to the levels of care provided and in accordance with the resident’s individual 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. | CI | Activities provided are appropriate to the needs, age and culture of the residents. Activities are developed by the three activities co-ordinators. Activities are overseen by an occupational therapist who meets with the staff and management to review the activities provided. The last review occurred 17 January 2018. Activities are developed using the residents’ profiles gathered during the admission interview with the residents and their families. Weekly activities are posted in the communal areas and up and coming events in the newsletter provided to residents and their families/whanau. Activities plans reviewed reflected the residents’ preferred activities and previous interests. Activities are provided more on a one to one basis with the hospital level residents, but if able, they are encouraged to join in the group activities. Special events are celebrated and there are specific activities provided for the three hospital level residents under the age of 65 years. Attendance at arranged activities is encouraged and attendance records are maintained. Recent resident and family events attracted fifty people to one (a pet event) and eighty people to a larger event which was highly successful and was enjoyed by the residents/staff interviewed. Family members spoke highly of the planning of events and most families participated and provided support to the staff and residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long term care plans as well as short term care plans are evaluated in a comprehensive and timely manner. Evaluations consider the residents’ degree of achievement towards meeting the desired goals and/or outcomes. The resident’s response to their treatment regime within the short term care plans is documented. Changes in the interventions in both long and short term care plans are made when goals are not achieved. Resolutions are documented in the short term care plans. |
| 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 which expires on 02 August 2019 is publicly displayed. There have been no changes to the facility footprint since the previous audit. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Data on infections is collated monthly and analysed to identify any significant trends or possible causative factors on a three monthly basis. Incidents of infections are presented at the quality assurance meetings and staff meetings. The necessary corrective actions are discussed. Incidents of infections are reported back to staff. A comparison of previous infection rates is used to analyse the effectiveness of the programme. The programme is appropriate for the size and nature of the service. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The facility was restraint free with no enablers or restraints in place at the time of the audit. The restraint coordinator (RN) would provide support and oversight for enabler and restraint management in the facility should they be used. The role and responsibilities of the restraint coordinator are described in policy.  Enablers are described in policy as the least restrictive and used voluntarily at the resident’s request.  Staff reported that restraint would only be used as a last resort when all alternatives have been explored. The restraint register identified that the last restraint used was in April 2016. |

# 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 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The activities programme provides a variety of activities to meet the needs of all residents. The content of the programme involves the participation of the activities coordinators, staff, residents, families and others from the community.  The three activities co-ordinators are passionate about their roles and are able to produce a programme that is meaningful and that meets the needs of all residents irrespective of individual acuity and needs. Regular reviews of the programme occur monthly and feedback is continually sought from the residents, family and staff. Families are encouraged at every opportunity to participate. There was evidence that the residents benefit from the interactions in this homely family orientated aged care setting as confirmed in documentation sighted and during interviews. Expertise in reviewing the activities programme is sought from the experienced occupational therapist. The staff, management and the general practitioner recently planned an annual fund-raising event with eighty guests and raised funds for a child health organisation. Family/residents and staff interviewed spoke highly of the event and the enjoyment for all concerned. Notice boards with photographs displayed are in all service areas and a monthly newsletter is distributed to the residents, their families and to staff which highlights comments and photographs of recent and up and coming events. | A continuous improvement rating is made for achievement beyond the expected full attainment for the activities provided for the residents at this rest home and hospital. Documentation identified that monthly reviews of the activities programme occurs with feedback being sought from residents, family and staff being used to evaluate the effectiveness and enjoyment of activities offered. Resident attendance and verbal comments are used to evaluate each activity offered. Evaluation of the programme includes the occupational therapist, family members, residents and staff. Feedback from resident meetings, the annual resident and family satisfaction surveys and everyday communication with residents and families are used to measure resident satisfaction. Any suggested changes are incorporated into the programme where appropriate. All activities are overseen by an experienced occupational therapist. Resident and family members interviewed confirmed their delight and satisfaction with the activities offered. |

End of the report.