

Milton Adams Limited - Cromwell House 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 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](#).

The specifics of this audit included:

Legal entity:	Milton Adams Limited
Premises audited:	Cromwell House Hospital
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 October 2018 End date: 23 October 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:	43

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

Indicator	Description	Definition
	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

Cromwell House Hospital provides rest home, hospital and secure dementia level care for up to 50 residents. The service is privately operated and managed by a facility manager and clinical leaders.

This surveillance audit was conducted against selected 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, families, management, staff and a general practitioner.

Since the last audit the facility has reconfigured its services to accommodate two more rest home residents by reducing hospital beds by two. This has been accomplished within current resources with no change to capacity.

The improvement required following the last audit in relation to the timeliness of InterRai assessments has not yet been fully addressed.

Five areas for improvement were identified at this audit relating to complaints records, adverse events, staff training, care plan assessments and the environment.

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.		Some standards applicable to this service partially attained and of low risk.
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There is open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained. Formal complaints had been 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.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided is regular and effective. An experienced and suitably qualified person manages the service. The facility manager is supported by clinical leaders who are registered nurses.

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 recorded. Appropriate

corrective actions are implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are 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. Staffing numbers and skill mix are adequate to meet the changing needs of residents in the rest home, hospital and dementia unit.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The clinical team is responsible for the development, evaluation of care plans and assessments. Short term care plans are developed for any acute needs as required.

Planned activities are appropriate for the residents' assessed needs and abilities. Residents and family/whanau interviewed expressed satisfaction with the activities provided by the diversional therapist (DT) and health care assistants.

The service uses pre-packaged medication system and is paper based. Medication is administered by staff with current medication competencies. Three monthly reviews are completed by the attending general practitioner (GP.).

Nutritious meals, snacks and fluids are provided in line with recognised nutritional guidelines. Residents who require special or modified meals are reliably catered for. Snacks and drinks are available 24 hours for residents if needed.

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.		Some standards applicable to this service partially attained and of low risk.
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Cromwell House Hospital consists of two buildings, one for the hospital level of care and one that has the secure dementia unit and the rest home level of care residents. The building warrant of fitness is current. Trial emergency evacuations are held every six months.

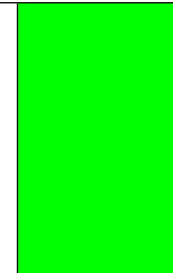
Restraint minimisation and safe practice

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.
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There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Environmental restraint is in place. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in the management of challenging behaviours.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection control coordinator is responsible for the surveillance programme, coordinating education, and training of staff. Surveillance for infection is carried out as specified in the infection control programme. The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	4	1	0	0
Criteria	0	37	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The complaints policy and associated forms/flow charts meet the requirements of Right 10 of the Code. The policy defines the actions/responses to take related to major and minor complaints. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to make a complaint if they wished to.</p> <p>The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed understanding of the complaint process and what actions are required. The complaints register records complaints, dates and actions taken. When sampled it showed that no complaints had been recorded since the last audit in 2017. It was identified during the audit that informal concerns expressed by clients / family or external sources are addressed but not recorded in the register.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they are kept informed about any changes to their/their relative's status, are advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Staff know how to access interpreter services, although reported this was rarely required with staff able to provide</p>

<p>provide an environment conducive to effective communication.</p>		<p>interpretation as and when needed with the use of communication aids and family members. There are appropriate processes and communication strategies recorded in care plans for residents with non-verbal communication and cognitive impairment.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Cromwell House Hospital provides rest home, hospital and secure dementia level of care for up to 50 residents. There are two buildings, one that contains the hospital and one that has the secure dementia unit and the rest home wing. At the time of audit there were 22 hospital residents (including two residents under the age of 65), three rest home residents and 18 residents living in the dementia unit. In July 2018 the facility was reconfigured to decrease hospital beds by two and increase rest home beds by two with no changes to overall capacity, facility layout, staffing or other resources required.</p> <p>The service is a privately-owned business with three directors. The directors have the governance responsibilities. The facility manager provides informal and formal communications and feedback to at least one of the directors at least weekly. The business plan records the scope, vision, mission statement, philosophy of the organisation with the organisational objectives documented. The plan is reviewed annually, with the specific plans, aims and ambition for 2018 recorded. The ongoing review of the goals and objectives is monitored through monthly staff meetings.</p> <p>The service is managed by a facility manager and two clinical leaders (registered nurses). The facility manager has responsibility for the overall operational management, with the support of the two clinical leaders responsible for the clinical aspects of service delivery. The facility manager has managed the service for over nine years. The facility manager is a member of an aged care association and attends over eight hours a year of professional development related to management of an aged care service. The facility manager receives weekly updates from the aged care association and has monthly updates related to employment and legislative changes from an employment association.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	<p>FA</p>	<p>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, resident/family feedback, monitoring of outcomes, clinical incidents including infections and restraint minimisation. Meeting minutes sampled confirmed regular review and analysis of quality data and outcomes of any quality audits/activities. Staff are involved in quality and risk management activities through internal audits and attendance at staff meetings.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey recorded overall high satisfaction with the care and service provided. Feedback has been addressed.</p> <p>Policies sampled cover all necessary aspects of the service and contractual requirements. The policies are developed by an aged care consultant and personalised to reflect the nature of the service. Policies are current and</p>

improvement principles.		<p>are referenced to best practice and legislation.</p> <p>All policies are version controlled, with staff only having access to the most recent version. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described and the risk register documents the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms that have occurred since the last audit showed that the immediate response to the event was fully completed and the incidents were investigated. Corrective and preventive action is not consistently implemented or verified in accord with facility policy. Adverse event data is collated, analysed and reported to staff through the monthly staff meetings.</p> <p>The facility manager is aware of essential notification reporting requirements. One significant incident had occurred and been notified to appropriate agencies since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of</p>	PA Low	<p>Human resource 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 confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role including dementia care. Staff reported that the orientation process prepared them well for their role. Staff records sampled have documentation of completed orientation and an initial education workbook that covers the aged care contractual requirements. In-service education is planned on a biannual basis, including mandatory training requirements. All staff who work in the dementia unit have either completed or are enrolled in the required dementia care education. The diversional therapist has completed education and qualifications related to dementia care.</p> <p>There are two trained and competent registered nurses who are maintaining their annual competency requirements</p>

legislation.		<p>to undertake interRAI assessment (refer to 1.3.3.3 for the implementation of interRAI).</p> <p>Facility policy requires performance reviews to be conducted annually. Four of the five staff files reviewed had not received the required performance review in the last 12 months.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery. The staffing numbers are based on safe staffing guidelines and the acuity of the residents. When there is an increased level of dependencies or needs, staffing is increased to match these increased needs. When a resident is admitted to the service, particularly the dementia unit, an extra staff member is allocated to provide one to one support to the new resident. The rosters sampled evidenced staffing numbers more than the minimum contractual requirements. The staffing numbers and skill mix meet the needs of the current residents and the layout of the facility for the residents at rest home, hospital and dementia level of care.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and sampling of rosters confirmed adequate nursing, care staff, diversional and housekeeping cover has been provided, with staff replaced in any unplanned absence. The kitchen and laundry services are provided by external service providers.</p> <p>There is at least one staff member on duty that has a current first aid certificate and there is 24 hour/seven days a week RN coverage in the hospital. Staff in the dementia unit have either completed or are enrolled in relevant training for dementia care.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>A documented medicines management system is implemented to ensure that residents receive medicines in a safe and timely manner. Medicine charts sampled complied with the required legislation, protocols and guidelines. The organisation uses pre-packed medicine packets which are checked by the RNs on delivery. All medicines are reviewed every three months and as required by the GP. Allergies are clearly indicated, and photos are available to assist with identification. Medicines are stored safely and securely in the treatment room, locked cupboards and drug trolley. Medicine reconciliation is conducted by the RNs when residents are admitted and when transferred back to the service. An annual medicine competency is completed for all staff administering medicines and training records were sighted. The Clinical leader (CL) and health care assistant were observed administering medicines correctly in the hospital and dementia wings respectively. The controlled drug register is current and correct. Weekly and six-monthly stock takes were conducted. There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. There were no residents self-administering medications at the service and a self-administration medication policy is in place if required.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Meal services are outsourced, and meals are prepared on site and served in the allocated dining rooms. The menu has been reviewed by the registered dietitian. Diets are modified as required and the cook confirmed awareness of dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night on a 24-hour period. Fluids are encouraged and monitored.</p> <p>The kitchen was audited and registered under the food control plan. Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted. The family/whanau interviewed acknowledged satisfaction with the food service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The documented interventions in short term care plans and lifestyle and nursing plan care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies were observed, and the staff confirmed they have access to the supplies and products they needed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The planned activities are meaningful to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Daily activities attendance record and activity progress notes are completed. Residents' files sampled reflect their preferred activities and are evaluated every six months or as when necessary. Files sampled had 24-hour activity plans in place to manage residents with behaviours of concern. The DT develop an activity planner for hospital, dementia, rest home and under 65 years residents. The DT has oversight of activities on the hospital wing conducted by healthcare assistants.</p> <p>The residents were observed to be participating in a variety of activities on the audit day. There are planned activities and community connections that are suitable for the residents. There are regular outings for all residents (as appropriate). Family/whanau and residents interviewed reported overall satisfaction with the level and variety of activities provided.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' lifestyle care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes (refer to 1.3.3.3). Relatives, residents and staff input are sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Acute nursing care plans are developed when needed and signed and closed out when acute problems have resolved.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The current building warrant of fitness is displayed.</p> <p>During the audit two areas of environmental risk were observed in relation to storage of rubbish and garden tools, and storage of cleaning chemicals.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an approved evacuation scheme. There have been no alterations to the buildings since then. Trial evacuations have taken place six-monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of the evacuation procedures.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Minutes of meetings and education records were sighted. An external consultancy firm has provided tools to enable monthly analysis of infections comparing with other health care providers. The GP is informed within the required time frame to prescribe antibiotics if any resident has an infection.</p>

and methods that have been specified in the infection control programme.		
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	The complaints system records complaints, dates and actions taken. When sampled it showed that no complaints had been recorded since the last audit in 2017. It was identified by the manager that informal concerns expressed by clients / family or external sources are addressed but not recorded in the register. Resident interviews identified a concern about presentation of meals; review of adverse events records revealed that a serious concern had been expressed by an external agency about aspects of the management of a patient incident. Neither were documented in the complaints system.	Informal concerns expressed by residents or external agencies are addressed but not recorded in or managed through the complaints system.	<p>Define those concerns, both formal and informal, that are to be captured in the complaints system and ensure that all corrective and preventive actions taken are recorded for quality improvement purposes.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse,</p>	PA Low	There is an accident and incident policy that defines appropriate actions to be taken following adverse events including resident falls. Records sampled indicated that actions following an event do not	Corrective and preventive actions following	Consistently document, implement and verify preventive actions as require by

<p>unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>		<p>consistently comply with the policy.</p> <p>Residents who have an unwitnessed fall do not consistently have a neurological assessment and on-going observations as required by the facility policy.</p> <p>Records do not include preventive actions taken to prevent a repeat of adverse events.</p> <p>The effectiveness of any actions taken is not verified and confirmed by the signature of the clinical leader or the manager.</p>	<p>adverse events are not consistently implemented or documented as required by documented policy.</p>	<p>the facility policy.</p> <p>90 days</p>
<p>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.</p>	<p>PA Low</p>	<p>Facility policy requires staff performance to be conducted annually. Three of four staff files reviewed had not received the required performance review in the last 12 months.</p>	<p>There is no evidence that staff performance is consistently reviewed annually as required by facility policy.</p>	<p>Maintain the annual performance reviews up to date.</p> <p>90 days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>Files sampled identified that initial care plans and lifestyle and nursing care plans were completed within the required time frames. InterRAI assessments and lifestyle nursing care plans are reviewed every six months or when there is any change in the condition of a resident however some of the files sampled had did not have current interRAI assessments in place.</p> <p>Monthly reviews are conducted by the GP for residents assessed as hospital level of care and three-monthly reviews for residents assessed as rest home and dementia level of care or as when required. Short term care plans are developed for short term problems or in the event of any change, with appropriate interventions to guide treatment. Resolution dates are documented, and care plans closed out.</p>	<p>Not all files sampled had current InterRAI assessments.</p>	<p>Ensure care plans are evaluated using current interRAI assessments.</p> <p>90 days</p>

<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>There are documented guidelines for management and safe storage of cleaning chemicals. There is secure storage for cleaning trolleys when not in use. It was observed that bottles of cleaning fluid had been left on a trolley accessible to residents in the hospital.</p> <p>External grounds are accessible via sealed level pathways with various areas through which residents may walk. During the audit it was observed that residents from the rest home have access to a yard where garden equipment and rubbish bins are stored.</p>	<p>Residents are not always protected from risk of harm in the environment:</p>	<p>Ensure that potentially harmful items and areas are secluded from access by residents.</p> <p>90 days</p>

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

No data to display

End of the report.