

Oakwoods Lifecare (2012) Limited - Oakwoods Retirement Village

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 Health and Disability Auditing New Zealand 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:

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| Legal entity: | Oakwoods Lifecare (2012) Limited |
| Premises audited: | Oakwoods Retirement Village |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 8 November 2018 End date: 8 November 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: | 49 |

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 |
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|  | 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 |
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| Yellow | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
| Red | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

General overview of the audit

Oakwoods Lifecare provides hospital and rest home level care for up to 91 residents. On the day of audit there were 49 residents. The service is managed by an experienced village manager who is supported by a clinical manager. The residents and relatives interviewed, all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service continues to implement the Arvida quality and risk management system.

The service has addressed the one shortfall from their previous audit in relation to dating medications.

This audit identified improvements required around annual performance appraisals and associated risks with the enabler.

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. |
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Communication with residents and families is appropriately managed. Families are regularly updated of residents' condition including any acute changes or incidents. Residents and family member interviewed verified ongoing involvement with the community. Complaints processes are implemented and managed in-line with the Code.

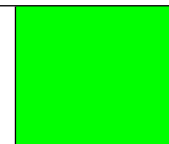
Organisational management

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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. | | Some standards applicable to this service partially attained and of low risk. |
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Oakwoods Lifecare is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted which generates opportunities for improvement. Corrective actions are developed and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care. Staffing is based on the occupancy and acuity of the 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.

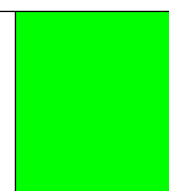


Standards applicable to this service fully attained.

The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in electronic resident records demonstrated service integration and were evaluated at least six monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. The registered nurses, enrolled nurse and senior caregivers responsible for administration of medicines complete annual education and medication competencies. The medicine charts reviewed met legislative prescribing requirements and were reviewed at least three monthly by the general practitioner. The diversional therapists provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in-line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

The building holds a current warrant of fitness.

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. | | Some standards applicable to this service partially attained and of low risk. |
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The service has policies and procedures to ensure that restraint is a last resort. At the time of the audit there were no residents with any restraints and four residents using enablers. Staff receive training in restraint minimisation.

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. |
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The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel 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 | 14 | 0 | 2 | 0 | 0 | 0 |
| Criteria | 0 | 39 | 0 | 2 | 0 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
|--|-------------------|---|
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is in place. There have been 18 complaints made in 2017 and 10 received in 2018 year to date. The complaints reviewed had been managed appropriately with acknowledgement, investigations and responses recorded. One complaint made through the DHB (staff related) in 2018 was followed up, investigated and closed off. Residents and family member advised that they are aware of the complaints procedure and how to access forms.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p> | FA | <p>Four residents (all rest home) interviewed, stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twelve incident/accidents had documented evidence of family notification or noted if family did not wish to be informed. Six relatives (three rest home and three hospital) interviewed, confirmed that they are notified of any changes in their family member's health status. Interpreter services are available as required.</p> |

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| communication. | | |
| <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> | FA | <p>Oakwoods Lifecare is owned and operated by the Arvida Group. The service provides care for up to 91 residents at hospital (geriatric and hospital) and rest home level care. This includes 43 serviced studio apartments that are certified for rest home level care. Forty-eight beds in the care centre are certified for dual-purpose (hospital and rest home). On the day of the audit, there were 49 residents in total; 24 residents at rest home level (including one resident on a long-term chronic medical condition (LTS-CHC) contract, one resident on respite care and one that resides in the serviced studio apartments), and 25 residents at hospital level (including two residents on younger persons with disabilities (YPD) contracts). All other residents were under the age-related residential care (ARRC) contract.</p> <p>The service is managed by an experienced village manager who has been in the role for 10 years. The village manager is supported by a clinical manager who has been in the position since 2 July 2018, and a clinical administrator/DT who has been in the role for five years. The village manager was absent at the time of the audit.</p> <p>The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. Oakwoods Lifecare has a business plan for 1 April 2017 to 31 March 2019 in place. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually. Regular meetings are held between the village manager and Arvida support office as well as weekly meetings between the village manager and clinical manager.</p> <p>The village manager has completed relevant training of over eight hours in the last 12 months and was present at a two-day managers' forum at the time of the audit.</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 improvement principles.</p> | FA | <p>There is a 2018 business/strategic plan that includes quality goals and risk management plans for Oakwoods Lifecare. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager is responsible for providing oversight of the quality programme on-site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. There are policies and procedures appropriate for service delivery, which are reviewed at least every two years across the group. Arvida support office sends out new/updated policies. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Meetings are held regularly, and review of meetings identify discussion of quality data, trends and outcomes. All staff interviewed could describe the quality programme corrective action process. Residents/relatives are surveyed to gather</p> |

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| | | <p>feedback on the service provided and the outcomes are communicated to residents, staff and families. The March 2018 resident/relative satisfaction survey overall result shows 100% satisfaction with services provided. There were no improvement areas required from the survey. Resident/family meetings occur three monthly and meeting minutes reviewed identified a proactive approach to address any concerns or feedback.</p> <p>The service has a health and safety management system that is regularly reviewed. Restraint and enabler use (when used) is reported within the facility staff meetings. Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee.</p> <p>The health and safety representative (cleaner) was interviewed and has completed health and safety training level two in their role. Hazard identification forms and a hazard register are in place. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</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> | FA | <p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A registered nurse (RN) conducts clinical follow-up of residents. Twelve incident forms (nine hospital and three rest home) reviewed for October 2018, demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for five unwitnessed falls or with potential head injury. Discussions with the clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 incident notifications completed since the last 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 legislation.</p> | PA Low | <p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Five staff files were reviewed (two RNs, two caregivers and one diversional therapist) included evidence of the recruitment process including police vetting, signed employment contracts, job descriptions and orientation checklists. Missing was evidence of completed annual performance appraisals in two staff files. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>Completed orientation is on files, and staff described the orientation programme. The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the district health</p> |

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| | | board (DHB). Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. There are six RNs and four have completed interRAI training. |
| <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>Oakwoods Lifecare has a weekly roster in place, which provides sufficient staffing cover for the provision of care and service to residents. The service has a total of 49 staff in various roles. Staffing rosters were sighted and there is staff on duty to meet the resident needs of different shifts. The village manager and clinical manager work 40 hours per week and are available on call after-hours. There is at least one RN on duty at all times. The RN on each shift is aware that extra staff can be called on for increased resident requirements. There are dedicated housekeeping and laundry staff. Interviews with staff, residents and relatives confirmed there are sufficient staff to meet the needs of residents. The service has 24 rest home residents (one rest home resident resides in the serviced apartments) and 25 hospital residents in the care centre.</p> <p>In the hospital unit there are 22 hospital and 8 rest home residents. There is an RN rostered on the morning, afternoon and night shifts. The RNs are supported by six caregivers (four long and two short shifts) on the morning shift, four caregivers on the afternoon shift (two long and two short shifts) and one caregiver on at night.</p> <p>In the rest home unit there are 15 rest home and 3 hospital residents. There is an enrolled nurse (EN) rostered on the morning shift. The EN is supported by one caregiver on the morning shift, there is one caregiver on the afternoon and one on night shifts. The clinical manager provides support during the day and completes care plans etc in the rest home.</p> <p>In the serviced apartments there is one rest home resident, there is an EN rostered on the morning shift who is supported by two caregivers rostered in the morning and two caregivers in the afternoon. The rest home night caregiver covers the serviced apartment residents. The hospital RN covers the afternoon and night shifts in the rest home unit and serviced apartments.</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</p> | FA | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs and enrolled nurse and senior caregivers) have been assessed for competency on an annual basis and attend annual medication education. All medication (blister packs) is checked on delivery against the paper-based medication chart. All medications are stored safely in the main medication room in the care centre. Locked medication safes are kept in each studio apartment from where the medication competent person administers the medication for the resident. The medication fridge is checked daily and is maintained within the acceptable temperature range.</p> <p>All eye drops were dated on opening. There is an imprest stock for hospital level residents. Expiry dates for 'as</p> |

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| guidelines. | | required' medications and stock are checked weekly. There were three residents (one hospital and two rest home) self-medicating on the day of audit. Self-medication competencies had been completed and reviewed three monthly. Ten medication charts reviewed met legislative requirements. The previous finding around prescribing and dating medications has been addressed. The paper-based medications had photo identification and allergy status identified. The medication charts had been reviewed three monthly by the GP. |
| <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> | FA | <p>All meals are prepared and cooked on-site. The Monday to Friday kitchen manager/chef oversees the food services. She is supported by a weekend cook and team of kitchenhands. Food services staff have attended food safety training. The food control plan has been verified and expires 3 May 2019. The four-weekly seasonal menu has been developed and reviewed by the company dietitian. The main meal is at midday and the evening meal provides two options. The meals are plated in the kitchen and delivered in heated cabinets to the rest home, hospital and studio apartment dining rooms. Resident preferences, dislikes and food allergies are known and accommodated. Modified diets are provided.</p> <p>Smoothies and fortified foods are provided on RN request. Fridge and freezer temperatures are taken and recorded daily. End-cooked food temperatures are recorded daily. Perishable foods sighted in the all fridges and the chiller were dated. Dry goods are dated. The dishwasher rinse and wash temperatures are recorded, and a monthly service check is carried out by the chemical supplier. Chemicals are stored safely. A cleaning schedule is maintained. Resident meetings along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</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> | FA | <p>When a resident's condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact in the resident progress notes on the electronic system that evidences family were notified of any changes to their relative's health including (but not limited to); accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Electronic wound assessments and treatment forms and ongoing evaluations were in place for eight residents with wounds including five skin tears, two abrasions and one chronic skin condition.</p> <p>There were no pressure injuries on the day of audit. The senior RN has attended the wound care conference and is a member of the wound care society. There is access to the wound nurse specialist if required. Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident</p> |

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| | | <p>nutritional status and preferences. Monitoring charts are completed on the electronic system such as pain, behaviour, neurological observations, blood pressure, weight, food and fluids and re-positioning. Work logs for the caregivers and RNs record cares and monitoring requirements as outlined in the care plans.</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> | FA | <p>The service employs two diversional therapists (DT) for the care centre who cover the Monday to Friday and alternate weekends. The rest home residents in the studio apartment may choose to join the studio apartment or rest home/hospital activity programme as desired. Activities are held in the dining rooms or lounges in the rest home or hospital. Some activities are integrated and at times there are two options of activities to attend when the two DTs are on duty or volunteers present to assist with activities. Residents are assisted to attend the activities. The activities are well displayed, and residents receive a copy of the programme. The team is well supported by the general manager of wellness at the Arvida support office.</p> <p>The programme runs from 10.30 am to 4.30 pm and reflects the household model of care. The activity team provides individual and group activities that meets the abilities and preferences of the residents. Activities include (but are not limited to); exercise groups, current events, reminiscing, baking (a portable oven is available), music, crafts, board games and walks. Residents enjoy monthly inter-home bowls and quizzes between three rest homes in the area. Volunteers assist with activities such as bingo, crafts baking, walks and the knitting group. One-on-one time is spent with residents who are unable to or chose not to participate in group activities. There are entertainers and community visitors including churches, preschool children and canine friends.</p> <p>There are regular outings/scenic drives for all residents. The service has two vans (one with wheelchair access). An individual activity assessment and leisure care plan for the younger person and resident under non-aged long-term chronic medical condition funding identify their interests and hobbies and community connections. The younger people are supported to attend community functions, activity centres and churches of their choice. A resident leisure profile is completed on admission. Individual activity plans were seen in long-term resident files. The DTs are involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through resident meetings (relatives invited) and survey. The residents interviewed were happy with the activities provided.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p> | FA | <p>All interim care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the RN six-monthly or earlier for any health changes for the long-term resident files reviewed. One resident was admitted for respite care and was not required to have an evaluation. Written evaluations reviewed identified if the resident goals had been met or unmet. Family are invited to attend the multidisciplinary care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are</p> |

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| timely manner. | | documented within the progress notes. |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | The building has a current building warrant of fitness that expires 1 December 2018. There is a reactive and planned maintenance schedule. |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected by the senior RN who is the infection control coordinator. Infections are based on signs, symptoms and the standard definition of infection. Infections are entered into the infection register on the electronic data base. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and analysed for trends monthly and annually. Infection control is discussed at facility meetings. There have been no outbreaks since the last audit. |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | PA Low | The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. At the time of the audit there were no restraints and four residents (all hospital) using enablers (two chair briefs and two lap belts). Files for the four residents with enablers showed that enabler use is voluntary. Assessment and consent forms were evidenced in the four resident files reviewed using enablers, however did not identify the enabler use or risks associated with the enabler. Staff received training on restraint minimisation in October 2018. |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|---|-------------------|---|--|--|
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | PA Low | The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the district health board (DHB). Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. Two of five staff files reviewed did not evidence an up to date annual appraisal. | Five staff files were reviewed, two of the five files did not have documented evidence of an up-to-date annual performance appraisal completed | <p>Ensure that all staff files include a completed annual performance appraisal</p> <p>90 days</p> |
| <p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least</p> | PA Low | The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were no restraints and four residents (all hospital) using enablers (two chair briefs | Four resident files were reviewed using enablers, there was | Ensure that the enabler use, or risks |

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| <p>restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p> | | <p>and two lap belts). The files for four residents with enablers showed that enabler use is voluntary. Assessment and consent forms were evidenced in the four resident files reviewed using enablers, however there was no documented evidence of identifying the enabler use or risks associated with the enabler in the care plan.</p> | <p>no documented evidence of identifying the enabler use or risks associated with the enabler in the care plan.</p> | <p>associated with the enabler are identified in the care plan.</p> <p>90 days</p> |
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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.

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End of the report.