Wairarapa Village Limited - Wairarapa 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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Wairarapa Village Limited
Premises audited:	Wairarapa Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 4 December 2018 End date: 5 December 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: 38

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

Wairarapa Village provides rest home, residential disability services-physical and hospital level of care for up to 48 residents. On the day of audit there were 38 residents residing at the facility.

This surveillance audit was conducted against the relevant streamlined Health and Disability Services Standards and the provider's contract with the Wairarapa District Health Board. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with family, residents by the consumer auditor, management, a general practitioner and clinical and non-clinical staff.

There were four areas identified as requiring improvement at the last certification audit. Two improvements relating to service provision requirements and personal space/bed areas has been met. Previous requirements for improvement relating to governance and review of policies and procedures remain open.

There are four new areas identified as requiring improvement at this surveillance audit relating to complaints management, quality improvement data, adverse event reporting and human resource management.

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.

Staff are informed of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service.

Information packs are provided to new residents and family members on entry to the service. Residents and family members confirmed they are involved with review of the individual care plans. Family are informed in a timely manner if any changes occur in the resident's condition. Residents and family meetings are held bi-monthly. Interpreter services are accessed when required.

The manager is responsible for management of complaints. Residents and family members confirmed on interview, that their rights are met. Staff were observed as being respectful of the resident's needs.

Organisational management

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

Wairarapa Village is governed by an owner/director. The manager is responsible for the overall management of the facility and is supported by the clinical coordinator and the owner. The manager and clinical coordinator are suitably qualified and have been in their roles for just under a year.

Quality and risk performance is monitored and reported to the owner. The facility has an incident and accident management system that records and reports all adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting. Documentation and interviews confirmed that staff communicate with residents and family members about incidents.

There are human resource policies in place and include recruitment, selection and appointment of appropriate staff. Orientation and regular training and education is provided. Staff competencies across a range of skills are also assessed routinely. Staffing is rostered to meet numbers of residents in the facility and acuity levels. Staff, residents and family confirmed that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

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.

Registered nurses assess residents on admission. Initial care plans guide service delivery during the first three weeks after admission.

The interRAI assessment process is used to identify residents' needs and completed within the required timeframes.

Electronic resident care plans are developed and implemented. Care plans are individualised and based on an integrated range of clinical information. Short-term care plans are in place to manage short-term problems. Residents' records reviewed demonstrated their needs, goals and outcomes are identified and reviewed at regular intervals. Interviews confirmed residents and their families are informed and involved in care planning and evaluation of care. Handovers between shifts guide continuity of care.

The activity programme is managed by the three diversional therapists and one activities coordinator. The diversional therapy individual plans are reviewed by the diversional therapists. The programme provides residents with a variety of individual and group activities. The service uses its facility van for outings in the community.

Medicine management occurs according to policies and procedure, in alignment with legislative requirements and is consistently implemented using an electronic system. Medications are administered by registered nurses and senior healthcare assistants. Medicines management competencies for staff who administer medicines were current.

The food service meets the nutritional and other specific needs of the residents. Staff have food safety qualifications. The kitchen was clean and meets food safety standards. The kitchen is registered and has been audited for the service's food safety plan. Residents confirmed satisfaction with meals.

Safe and appropriate environment

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

The building has a current building warrant of fitness. There have been no building modifications since the last audit. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

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 implements policies and procedures that support the minimisation of restraint.

There were eight enablers in use and four residents were using restraints at the time of audit. Restraint is only used as a last resort when all other options have been explored. When enablers are used, enabler use is voluntary. Staff interviews confirmed 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 surveillance is undertaken, analysed and trended. Results are reported to the manager. Surveillance records showed evidence of follow-up of infection when required.

The infection surveillance programme is reviewed annually. Staff demonstrated current knowledge and practice in relation to the implementation of infection prevention and control.

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	3	2	0	0
Criteria	0	34	0	4	2	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The complaints management policy meets Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The complaint forms and the complaints process are accessible to staff, residents and family. Residents and family are advised of the complaints process on admission. Residents and family interviewed demonstrated an understanding and awareness of how to make a complaint. Staff confirmed that they understand and implement the complaints process when required. However, there is no complaints register and management of complaints is not documented in line with Right 10 of the Code. The manager is responsible for the management of complaints at the facility. Bi-monthly resident meeting minutes confirmed that residents and their families/enduring power of attorney (EPOA) are able to raise any issues they have during these meetings. There have been no complaints to external agencies.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	Information about the service in brochures and information leaflets, is provided to prospective residents and their families on enquiry prior to admission. The resident admission agreement, signed by residents or their representative on entry to the service, details information about services provision. There are bi-monthly resident and family meetings. Interviews with residents and family confirmed that they attend meetings and are able to raise any concerns they may have. Meeting minutes demonstrate

communication.		that residents and family are advised of a range of facility updates and take the opportunity to provide feedback into service delivery, as well as raise any concerns. Review of residents' clinical files evidenced timely and open communication with residents and family members. Communication with family members is recorded in the progress notes and communication records. Staff and management interviews confirmed family members are kept informed about any change in a resident's condition and if any adverse event occurs. This was evidenced in clinical files reviewed. The family interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Interpreter services are accessible, when required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low	The service has documented values and goals. These are communicated to residents, staff and family through visual display on the wall, information in booklets and in staff training. The business plan is in draft dated 2016-2017. The plan is focussed on the care of older persons. The goals and philosophy do not include the needs of the younger persons with disabilities (YPD) residing at the facility. This was a requirement for improvement at the previous audit which remains open. Wairarapa Village owner provides support to the service. The manager is responsible for the overall provision of services at Wairarapa Village has been in their role since February 2018 and is a registered nurse (RN). The clinical care service is overseen by the clinical coordinator (CC) who is a RN and has been in this position for approximately nine months. Both the manager and the CC attend study days and additional training and education specific to management, exceeding eight hours annually. There is no documented evidence HealthCERT were informed of the new appointments at the facility (refer to 1.2.7.3). The facility is certified to provide residential care for rest home, hospital, residential disability-physical service types. The facility can provide care for up to 48 residents with 38 beds occupied on days of audit. This included 15 residents requiring rest home level care, including 1 under occupational right agreement and 3 residential disability-physical. There were 23 residents requiring hospital level care including 3 residential disability-physical residents. The facility also holds contracts with the district health board for respite care. Included in occupancy numbers were two respite residents including one at rest home and one at hospital level care.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an	PA Moderate	The service implements organisational policies and procedures to support service delivery. Not all policies and procedures are current. The previous requirement for improvement relating to some policies reflecting the previous owner's practice and policies not being specific to the needs of younger persons, remains open. There is currently no documented evidence of a document control system to ensure that

established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		obsolete documents are removed from use. Staff stated they are informed of new and revised policies. Service delivery is monitored through: incidents and accidents; and implementation of an internal audit programme. Regular audits are undertaken and corrective action planning put in place to manage any shortfalls identified. Results of service delivery indicators are not always analysed and discussed at relevant meetings. The service has a documented health and safety programme, which includes managing hazards, reporting and investigating accidents, planning for emergencies, and health and safety education. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Interviews with residents confirmed they have opportunity to contribute to quality improvement processes. This includes expressing preferences regarding meals, their care, the use of equipment and their social activities. Interviews with residents by the consumer auditor, including younger persons, confirmed they have opportunity to contribute to quality improvement processes, however, there was no documented evidence of this being implemented.
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.	PA Moderate	Management understood their obligations in relation to essential notification reporting and know which regulatory bodies must be notified as confirmed in interviews. Excluding new management notification, there have been no other events that have required essential notification to the appropriate authorities since the previous audit (refer to 1.2.7.3). The incident/accident reporting processes are documented. Management confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated. Corrective action plans to address areas requiring improvement were documented on incident/accident forms sighted. Staff stated they report and record all incidents and accidents. Residents' files evidenced staff document adverse, unplanned or untoward events on accident/incident forms. The RNs are responsible to undertake assessments of residents following an incident/accident. However, incident/accident reports related to falls did not evidence implementation of post fall actions.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in	PA Low	Staff that require professional qualifications have them validated as part of the employment process. Annual practising certificates were sighted for all staff who require them and these are validated annually. Management stated staff complete an orientation programme that covers the essential components of health and safety and service delivery, with specific competencies for their roles. Orientation checklists

accordance with good employment practice and meet the requirements of legislation.		were sighted in all staff files reviewed. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly describe staff responsibilities and best practice standards, as sighted in staff files reviewed. There is no appraisal schedule in place and staff appraisals were not consistently completed. Staff education is provided to all staff. Mandatory education and training in the required areas relevant to the levels of staff responsibilities and authority are completed. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided. Staff participate in education relevant to young persons with disabilities. Competency assessments are current for medication management and restraint. The manager and CC have completed the required interRAI training. Two RNs are in training and another two RNs are scheduled for training. The resident receiving rest home care level care under an ORA has their needs met within the environment in which they live and are supported by appropriate staff to meet their needs.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing rationale guidelines form the foundation for workforce planning. Staffing ratios are based on the numbers of residents by service type and the number of care hours to meet resident acuity. Staff interviewed stated that staffing levels are reviewed and allocated according to anticipated workloads. In addition they identified resident numbers and appropriate staff skill mix, or as required due to changes in the services provided. Rosters reviewed confirmed adequate numbers of suitably qualified staff are on duty to provide safe and quality care. There is an RN on duty on every shift. The CC and the manager are on call after hours and weekends. The on-call arrangements are known to staff. In the advent of leave for the manager, the CC provides cover. Residents interviewed stated their needs are met in a timely manner. The resident receiving rest home level care with an ORA has their needs met within the environment in which they live with 24-hour care and sufficient staffing and availability of RNs to meet their needs in accordance with the aged related residential care agreement.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	FA	The medicine management system is documented and implemented and complies with legislation, protocols and guidelines. The service uses pharmacy pre-packaged medicine that is checked by the RN on delivery. An electronic medication system is used. Weekly checks and six-monthly stocktakes are conducted and confirmed that stock levels were correct.

guidelines.		The medication refrigerator temperatures are monitored. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are stored appropriately. Review of the medication fridge confirmed that the service does not store or hold vaccines and interviews with the RN and the CC confirmed they do not hold any vaccines on the premises. The staff administering medication complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled where applicable. There was one resident self-administering medication during the onsite audit days. A process is in place to ensure ongoing competency of the resident and this is authorised by the GP. Medication is blister packed and stored safely.
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 on site and served in two different dining rooms. The seasonal menu has been reviewed by a dietitian. The food control plan's expiry date for implementation is July 2019. Kitchen staff have current food management certificates. Residents' dietary profiles are developed on admission and identify the residents' dietary requirements and preferences. The dietary profiles are communicated to kitchen staff on a resident's admission to the facility, when a resident's dietary needs change and when dietary profiles are reviewed six monthly. Diets are modified as required and the chef confirmed awareness of the dietary needs of residents. Supplements are provided to residents with identified weight loss problems. All food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit meets the requirements of the standard. The chef is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges which are daily monitored and dry food supplies are stored in the pantry.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The residents' care plans are completed by the RN and based on assessed needs, desired outcomes and goals of the residents. Care planning includes specific interventions for both long-term and acute problems. The GP documentation and records were current. Interviews with residents and families confirmed that care and treatment meets residents' needs. Staff interviews confirmed they are familiar with the needs of the residents. Family communication is recorded in the communication records in the residents' files. The nursing progress notes and observation records are maintained.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The residents' activities programme is developed by the three diversional therapists and one activities coordinator. The staff cover and provide activities for the residents seven days a week. The activities programme was reviewed, displayed and implemented. The diversional therapists plan a range of activities which incorporate education, leisure, cultural and community events for the residents, including YPDs, to participate in if they choose to do so. The residents' activities assessments are completed within the three weeks of the residents' admission to the facility. Information on residents' interests are gathered during an interview with the resident and their family. The diversional therapists develop an activities care plan for each resident, including YPDs, that reflects the individual resident's preferred activities. The activities plans are reviewed six monthly at the same time the care plans are reviewed. There was evidence the activities staff are part of the interRAI evaluation process. The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging in a variety of activities and outings.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The long-term care plans and the short-term care plans are evaluated in a timely manner. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Residents' responses to their treatment are documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. Short-term care plans are developed for acute problems when needed and record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building warrant of fitness is current. The manager stated there have been no alteration to the buildings since the last certification audit.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with	FA	There is adequate personal space provided in all bedrooms. Residents and staff can move around within the room safely. Residents interviewed all spoke positively about their rooms. In rooms requiring equipment there is sufficient space for the equipment, a hoist, at least two staff and the resident. The

adequate personal space/bed areas appropriate to the consumer group and setting.		previous requirement for improvement relating to not all designated dual purpose rooms being large enough to deliver all hospital level services, has been closed out.
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	The infection control programme is site specific and reviewed annually. The surveillance policy identifies the requirements around the surveillance of infections. The infection logs are maintained and collated monthly by the CC. The CC is the infection prevention and control nurse. Residents' files evidenced that those residents diagnosed with an infection had short-term care plans in place. The GP interview confirmed infections are reported in a timely manner. In interviews, staff reported they are made aware of any infections through feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was confirmed during attendance at the handover and review of the residents' files. The CC confirmed that there had been no outbreaks of infection at the facility since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The Wairarapa Village restraint minimisation policies and procedures comply with legislative requirements. The restraint coordinator is the CC. A signed position description was sighted. There were eight residents using enablers at the time of the on-site audit. Interviews with staff confirmed that enabler use is voluntary. At the time of the on-site audit the service had four residents using restraints. The restraint register is maintained and current. Required documentation relating to restraint is recorded. Staff receive restraint education as part of the ongoing education programme and RN study days.

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)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	Complaints and compliments forms are displayed for residents/family to use if required. The complaints and compliment form that incorporates an outline of the complaints process for residents and family/EPOA. Residents and family interviewed confirmed having an understanding and awareness of complaints processes, and that any issues raised were addressed. Complaints may be lodged anonymously. However, complaints are not recorded on a complaints register. Complaints management documentation is incomplete (e.g. timeframes and actions taken not documented).	i) The service does not currently maintain a complaints register. ii) Complaints management documentation is not completed as per Right 10 of the Code.	i) Maintain a complaints register, reflecting the management of all complaints. ii) Complaints management documentation to be completed as per Right 10 of the Code. 90 days
Criterion 1.2.1.1 The purpose, values,	PA Low	The organisation’s vision, values and philosophy are displayed on the wall at the entrance to the facility and the philosophy is	i) The business plan is not current.	i) Review the business plan.

scope, direction, and goals of the organisation are clearly identified and regularly reviewed.		communicated to residents in the facility's information booklet upon admission and to staff at orientation. However, the business plan has not been reviewed annually and does not document a specific service plan for younger person's residential disability residents.	ii) The business plan does not include a specific service plan for the care of YPD residents.	ii) Ensure the business plan includes specific service goals for services to YPD residents. 180 days
Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.	PA Moderate	Wairarapa Village implements organisational policies and procedures to support service delivery. Not all policies in use have been updated and reviewed since the change in ownership and still reflect the previous owner's practice. The policies and procedures do not address the specific needs and aspirations of the younger people who reside at the facility. There is no system to manage policies and policies do not have evidence of document control.	i) Not all policies are current and some of the policies still refer to the previous provider. ii) Policies do not reflect the needs of YPD residents. iii) There is currently no system for the management of policies and/or document control.	i) Review all policies to reflect the current providers' services. ii) Policies to reflect the needs to YPD residents. iii) Implement a system for the management of policies and to ensure appropriate document control. 180 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate,	PA Low	Data related to quality improvement is collected through the internal audit programme and incident/accidents. However, there is no documented evidence of analysis or evaluation of data. Staff meeting minutes do not evidence quality improvement data is discussed. Interviews confirmed YPD residents are able to express their preferences regarding meals, their care, the use of equipment and their social activities. However, the quality system does not include	i) There is no documented evidence that quality improvement data is analysed/evaluated. ii) There is no documented	i) Document quality improvement analysis, evaluations and outcomes. ii) Ensure quality improvement

consumers.		initiatives to ensure continuous improvements for YPD.	evidence that quality improvement data/outcomes is communicated to service providers. iii) Continuous improvement initiatives for YPD residents are not included in the quality system.	data/outcomes are communicated to service providers. iii) Continuous improvement initiatives for YPD residents to be included in the quality system. 180 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Incident/accident forms reviewed evidenced incident/accidents are investigated and closed out and there is evidence that corrective actions are implemented. Registered nurses are responsible for completing assessments following an accident/incidents. These are documented on an accident/incident form and kept in the resident's clinical file. Review of five of five incident/accident forms for residents with unwitnessed falls evidenced neurological observations were not documented. Post falls risk assessments were not consistently recorded and the RN assessments do not document timeframes.	i) Incident/accident reports for residents who experienced unobserved falls do not evidence neurological observations over 24 hours. ii) Post falls risks are assessments are not consistently recorded. iii) Registered nurse reviews of residents who fall do not consistently document the timeframes for when assessments and interventions were completed post fall.	i) Incidents/accident records for residents who have unobserved falls to evidence documentation of neurological observations over 24 hours. ii) Ensure post falls assessments are completed for residents who fall. iii) Ensure registered nurses document timeframes when assessments and interventions are completed post fall.

				90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	The manager, CC and RNs hold current annual practising certificates and these are validated annually. Staff files include employment documentation such as job descriptions and contracts on file. Staff receive orientation and ongoing education and training relevant to their roles. There is no documented system for managing staff appraisals. Staff files reviewed evidenced not all staff had a current performance appraisal. There was no documented evidence HealthCERT was made aware of staff changes in management roles.	i) Staff files reviewed did not all include current performance reviews. ii) There was no evidence that the changes in management roles were reported to HealthCERT.	i) All staff to have current performance reviews completed annually. ii) Ensure HealthCERT is notified of the changes in the management roles. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.