# Castlewood Nursing Home Limited - Castlewood Nursing Home

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Castlewood Nursing Home Limited

**Premises audited:** Castlewood Nursing Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 January 2019 End date: 24 January 2019

**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:** 17

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Castlewood Nursing Home provides rest home level care for up to 24 residents. Occupancy on the first day of audit was at 17residents.

This surveillance audit was conducted against the relevant Health and Disability Services Standards and the provider’s contract with the district health board.

The audit process included the review of policies, procedures, residents and staff files, and observations and interviews with residents, family, management, general practitioner and staff.

Family and residents interviewed spoke positively about the care provided. There were 12 areas identified as requiring improvement at the last certification audit. Two improvements relating to governance, six relating to quality and risk management systems, two relating to human resource management and one relating to service provider availability. These were implemented. There is one previous requirement for improvement relating to corrective action plans which remains open.

There are two new areas identified as requiring improvement relating to meeting frequency and minutes to be aligned with the meetings policy and performance reviews to be completed in a timely manner.

## 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. |

Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family. 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.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices relating to the care they receive. Linkages with family and the community are encouraged and maintained. The service has a documented and implemented complaints management system. The clinical nurse manager is responsible for management of complaints.

## 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. |

The organisation's mission statement and vision are documented. Castlewood Nursing Home is governed by the owner. The clinical nurse manager is responsible for the overall management of the facility and is supported by the registered nurse and the owner. The clinical nurse manager and the registered nurse are suitably qualified

Quality and risk performance is monitored and reported to the owner. The registered nurse collects and evaluates data and monitors key components of clinical care. Results are shared with staff.

There are processes in place for incident/accident management to record and report all adverse, unplanned or untoward events. Adverse events are documented and discussed with residents and/or their family. The clinical nurse manager understands their statutory obligations regarding essential notification.

Orientation and regular training and education is provided. Staff confirmed they receive training.

Staffing levels meet occupancy and acuity levels and residents state they have adequate access to staff when needed. Duty rosters sighted confirm that there is adequate staff available and staff confirmed they are aware of the process to assure safe staffing afterhours.

## Continuum of service delivery

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

Residents receive services from suitably qualified and experienced staff. The residents’ files reviewed demonstrated the initial care plans were conducted within the required timeframes.

Care plan evaluations are documented, resident-focused and indicate progress towards meeting the desired outcomes. Where an acute problem occurs a short-term care plan is completed. Residents and family members have an opportunity to contribute to assessments, care planning and evaluations of care.

Activities are planned and the activities programme includes a wide range of activities and involvement with the wider community.

The medicines management system is documented and implemented to provide safe processes for prescribing, administration and medication reconciliation, dispensing, storage and disposal of medicines. Staff responsible for medicines management complete annual medication competencies.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines. There is a central kitchen and on-site staff that provide the food service. The kitchen staff have completed food safety training.

## Safe and appropriate environment

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

The building has a current building warrant of fitness. There have been no building modifications since the last audit.

## Restraint minimisation and safe practice

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

The service has documented policies and procedures for restraint minimisation and safe practice. Staff interviewed confirmed that enabler use is voluntary. There were no residents using restraint or enablers at time of audit.

## 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. |

Surveillance for infections is undertaken monthly. Results of surveillance are analysed to assist in achieving infection reduction. The infection surveillance results are reported to staff and management in a timely manner.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 14 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 2 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service’s complaints policy and procedures are in line with the Health and Disability Commissioner’s Code of Health and Disability Consumers’ Rights (the Code) and include timeframes for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved.  Evidence relating to each logged complaint is held in the complaints folder and register. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner. Staff, residents and family confirmed they are aware of the complaints process. Residents and family stated that these are dealt with as soon as they are identified. The clinical nurse manager is responsible for complaints.  There have been no complaints lodged with the Health and Disability Commissioner or any other external authorities since the previous audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and their families receive information available in the form of brochures and information leaflets. This information is provided on enquiry, prior to admission. Resident meetings are held bi-monthly and there is the opportunity for residents to provide feedback at these meetings. There is evidence that resident feedback is acted upon and residents updated at subsequent meetings.  The facility has an implemented open disclosure policy that defines the principles of open disclosure. Review of residents’ clinical files evidenced timely and open communication with residents and family members. The residents' files reviewed provided evidence that communication with family members is documented in the resident’s progress notes. Interpreter services can be accessed through Southern District Health Board and the process is described in policy. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Castlewood Nursing Home has a documented mission statement in the business plan. The business plan includes documented responsibilities and performance measures for monitoring and review. The previous requirement for improvement relating to a planned, coordinated approach to services, including key performance indicators, being reflected in governance documents has been closed out.  The clinical nurse manager (CNM) is a registered nurse (RN) and responsible for the overall management of the facility. The CMN reports to the owner who lives on site. The CNM attends training opportunities at the DHB and has been in this position for 18 months having previously worked in the service as the RN. There is a signed contract and job description in their staff file (refer to 1.2.7.3). The CNM and the RN job share clinical responsibilities. The RN has been in their role less than a year. Both the CNM and RN had current practising certificates and have previous experience in caring for older people. The previous requirement for improvement for the organisation to be managed by a suitably qualified person has been closed out.  There are monthly meetings which include clinical, quality and risk management, management and staff meetings (refer to 1.2.3.8).  Castlewood Nursing Home has contracts with the Southland District Heath Board for rest home services and aged related residential respite care. The facility can provide care for up to 24 residents requiring rest home level of care, with 17 rest home residents in the service on the days of the audit. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Review of the newly implemented quality and risk management system provided evidence that the CNM and staff understand the systems and processes.  The service implements policies and procedures to guide service delivery which are aligned with good practice. The policies and procedures meet current legislative, health and disability standards or contractual requirements. An abuse and neglect prevention/management policy and an interpreter policy are now in place. The previous requirement for improvement related to policies has been implemented. Staff were able to demonstrate their understanding and knowledge of policies. There is a formal process in place for document control. Documents are reviewed, up to date and available to staff. The previous requirement for improvement has been closed out.  Service delivery is monitored through review of complaints and review of incidents and accidents with monthly analysis of data, completed by the RN and reported to the CNM. This information explicitly links to the quality management system. Quality improvement data is collected, analysed, and evaluated and the results communicated to staff. The previous requirement for improvement to link key components of service delivery to the quality and risk framework has been implemented.  There is evidence of incidents, accidents and complaints being managed in a timely manner with relevant corrective actions reflected in the residents’ files where applicable. A current organisational audit schedule was in place. There was evidence of nursing audits activity occurring. The internal audit system measures achievement against the quality and risk management plan and the previous requirement for improvement has been closed out.  There are two monthly residents’ meetings. Meeting minutes record quality improvements and evidence that families are invited to attend. The service implements staff, quality and other meetings with documented meeting minutes. However, the meeting types and frequency of meetings are not consistently aligned with policy.  The requirement for the service to ensure corrective action plans are developed and closed out, remains open as the corrective action processes to identify, implement and document corrective actions arising from meeting minutes are not fully implemented.  There are processes to ensure monitoring and management of risk were implemented, this included a new risk register and new policies for the management of risk. The previous requirement for improvement has been closed out.  The previous requirement has been closed as there is overarching monitoring and reporting at management level. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The CNM is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police attending the facility, sentinel events, infectious disease outbreaks and changes in key management roles. Evidence was sighted confirming that the Ministry of Health had been notified of the CNM appointment.  Staff interviews and review of documentation showed that staff document adverse, unplanned or untoward events on an accident/incident forms. Incident and accident records are signed off by the CNM. There is a process which is implemented for neurological observations to be completed for possible and actual head injuries; such as un-observed falls, when required. There have been no deaths referred to the coroner. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Castlewood Nursing Home has documented human resource management policies and procedures. The skills and knowledge required for each position is documented in job descriptions including a job description for the CNM. Staff files reviewed, along with employment agreements included: reference checks; copies of current practicing certificates; police vetting; and completed orientations. The previous requirement for improvement related to verification of annual practising certificates and a job description for the CNM have been implemented. However, not all staff had timely performance reviews completed.  The service has scheduled monthly in-service training as part of the monthly staff meetings as evidenced in meeting notes. There was documentation to verify the content of the in-service training programme and attendance records are maintained. The previous requirement for improvement relating to staff education is now implemented. Both the CNM and the RN completed interRAI assessments training and competencies.  An orientation/induction programme is available and new staff are required to demonstrate competency on a number of tasks, including personal cares. The staff orientation covers the essential components of the service provided. Caregivers confirmed their involvement in supporting and buddying new staff. Annual competencies are required to be completed by clinical staff. There was evidence in the clinical staff files reviewed of competencies completed for staff. |
| 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 service has an implemented staffing policy and rationale reflecting good practice. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix. Staffing levels are adjusted as required due to changes in acuity and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy. On review of rosters, sufficient cover was evidenced.  The CNM and RN provide cover across 40 hours per week. Monday to Friday the service has a RN with two caregivers in the morning and two caregivers on duty at night. The caregivers have access to the RN or the CNM over weekends, should they need clinical input into care. There are 18 staff, including the CNM, RN, caregivers, an activities coordinator and maintenance and household staff. There is a written process for on-call management. When the activities coordinator is not working or on leave there is provision for caregivers to provide activities to residents. The service now has a process in place formalising safe staffing management including skill mix; acuity levels; escalation planning; on-call arrangements and leave cover for the activities coordinator.  The previous requirement for improvement relating to service having clearly documented process for determining levels and skill mix in order to provide safe service delivery has been closed. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication policy is current and meets legislative criteria. Medication areas evidence an appropriate, secure medicine dispensing system which is free from heat, moisture and light, with medicines stored in original dispensed packs. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs check medications against the prescriptions when delivered from the pharmacy. There is a process for checking and managing expired medicines. All medications sighted were within current use by dates. Weekly checks and six monthly physical stocktakes of medications are conducted. The weekly records of temperature for the medicine fridge confirm these are within the recommended temperature range.  Senior caregivers and two RNs authorised to administer medicines have current competencies. The medication round observed evidenced safe practice. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.  There is a current standing orders sheet in each individual resident’s medication record which are reviewed by their GP annually. There were no residents self-administering medication on the day of audit. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided by an experienced cook Monday to Friday. The CNM and a relief cook provide cover on the weekends. The staff working in the kitchen have completed relevant food safety training. Food procurement; production; preparation; storage; transportation; delivery and disposal complies with current legislation and guidelines. There is a current food control plan which had been verified in January 2019.  The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people. There is a four weekly winter and summer menu. The menu had been reviewed by a dietitian in June 2018. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet residents’ nutritional needs, where required, was sighted. There is sufficient staff on duty in the dining rooms at meal times to ensure assistance is available to residents as needed.  The residents’ satisfaction with meals was verified by resident and family interviews and resident meeting minutes. |
| 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 LTCPs reviewed evidence detailed interventions based on individual assessed needs and desired outcomes or goals of residents. The GP documentation and records were current. In interviews, residents and family confirmed current care and treatment needs are met.  Family communication is recorded in the residents’ files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.  Observation evidenced there were sufficient supplies of equipment available that complied with best practice guidelines and met the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by an activities coordinator. A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents’ activity needs are evaluated as part of the formal six monthly LTCPs review.  The planned monthly activities programme sighted matches the skills, likes, dislikes, and interests identified in residents’ assessment data reviewed. The activities reflected residents’ goals, ordinary patterns of life and include community activities. Individual and group activities, and regular events are offered. The activities programme is discussed at the residents’ meetings and meeting minutes indicated residents’ input is sought and responded to.  Residents interviewed confirmed they find the programme meets their needs. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the residents’ progress notes. If there are any changes noted, it is recorded in the handover record, communication diary and reported to the RN.  Formal LTCP evaluations, following reassessment, including interRAI assessment, to measure the degree of a resident’s response in relation to desired outcomes and goals, occur every six months or as residents need change. Care plan evaluations are conducted by the RN, with input from residents, family and caregivers. There was evidence of allied health care staff input when this was required.  There was evidence a STCP is initiated for short-term concerns such as wounds and infections. Short-term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. If the problem is ongoing, the LTCP is updated to reflect the problem. Interviews verified residents and family are included and informed of all changes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed in a visible location at the entrance to the facility. There have been no structural alterations since the previous audit. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection prevention and control surveillance policy identifies the requirements around the surveillance of infections. The type of surveillance undertaken is appropriate to the size and complexity of this service. Infection logs are maintained for infection events. Monthly surveillance analysis is completed and reported at monthly staff meetings.  The residents’ files evidenced the residents who were diagnosed with an infection had STCPs in place.  In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the CNM, RN, verbal handovers, STCPs and progress notes. This was evidenced during attendance at the staff handover and review of the residents’ files.  Interview with the RN confirmed there have been no outbreaks in the facility since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler is congruent with the definition in the standard. The CNM is the restraint coordinator. Staff interviewed understood the restraint/enabler process. Staff reported, if used, enablers are voluntary and are the least restrictive option. Review of training records evidenced education was provided.  On the day of the audit, no residents were using restraints or enablers. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Corrective action plans are developed and closed out for incident and accident processes. There are monthly staff meetings with meeting minutes and evidence of corrective actions being documented. There are quality and other meetings occurring. Meeting minutes for these meetings are documented, however, the type of meetings and timeframes for meetings are not aligned with the guidelines in the meeting minutes policy.  Corrective actions identified in meeting minutes (except for staff meetings) do not consistently document the required corrective action, person responsible for the implementation of change timeframes for implementation or the sign-off of corrective actions. | i) The type of meetings and the timeframes for having the meetings do not align with the meetings policy.  ii) Corrective action plans resulting from meetings are not always documented and implemented. | i) Ensure the type of meeting and frequency of meetings aligns with policy.  ii) Ensure corrective actions plans resulting from meetings are documented and implemented.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | There are processes in place to ensure the appointment of appropriate staff occurs. However, three of five staff folders reviewed showed that three staff members did not have performance reviews completed. | Performance reviews are not consistently completed for all staff. | Ensure all staff have performance reviews completed annually.  90 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.

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| No data to display |

End of the report.