

Fairview Care Limited - Fairview Care

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Fairview Care Limited
Premises audited:	Fairview Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 April 2019 End date: 16 April 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:	46

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

Fairview Care Limited (Fairview Care) provides rest home and hospital level care for up to 47 residents. The service is operated by Premiere Lifestyle Limited and managed by a care manager and clinical nurse leader. Residents and families spoke positively about the care provided.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with the chief executive officer (CEO), residents, family members, the general practitioner (GP), management and staff.

This audit has resulted in three areas requiring improvement relating to interRAI assessments, resident satisfaction surveys and staff emergency training 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.		Standards applicable to this service fully attained.
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At Fairview Care, open communication between staff, residents and families is promoted. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. There are policies in place to support assessment, planning, provision of care, evaluation and exits for residents to safely meet the needs of the residents and contractual requirements.

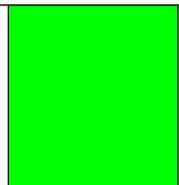
Residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident's needs a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

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.
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There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Eight enablers were in use at the time of audit. No restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, 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	13	0	3	0	0	0
Criteria	0	36	0	3	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 complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that three complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The care manager is responsible for complaints management and follow up. The Chief Executive Officer (CEO) confirmed he is kept informed of all complaints. All staff interviewed demonstrated a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Staff know how to access interpreter services. At the time of audit one resident did not speak English; however, staff are able to provide interpretation as and when needed, along with family members as required.</p>

environment conducive to effective 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>The strategic and business plans, which are reviewed annually, outline the purpose, vision, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of weekly email reports to the CEO from the care manager and monthly written reports to the board of directors/owners showed adequate information to monitor performance is reported including financial performance, quality data information, emerging risks and issues. The CEO has overall responsibility for the services offered at Fairview Care and Fairview Village which is part of the same complex. The CEO reports directly to the board of trustees which consists of four members, the chairman/director, two owner/directors and one independent board member. It was confirmed during interview that documented reporting occurs monthly or more regularly if any major issues arise.</p> <p>The care service is managed by a registered nurse who is the care manager. She holds relevant qualifications including a Masters in Nursing (Massey University 2013) and a level four certificate in management (EMA). She has been in the current role for 18 months. Prior to a restructuring of roles, the care manager was the clinical manager at the facility for three and a half years. She is supported by the clinical nurse leader (CNL) who is also a registered nurse with over six years' experience in aged care and has been in the role since January 2018. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The care manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through regular clinical and management education.</p> <p>The service holds an Age Related Residential Care (ARRC) contract with Waitemata District Health Board (WDHB) for hospital and rest home level care which includes respite. Forty-six residents were receiving services under the ARRC contract being five rest home level care and 41 hospital level care at the time of 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</p>	PA Low	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, monitoring of outcomes, clinical incidents including infections, wounds and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at management and staff meetings. The monthly registered nurse meeting is used to monitor quality and risk and quality data findings. Staff reported their involvement in quality and risk management activities through being members of specific committees such as infection control, falls, nutrition and restraint as well as undertaking audit activities, and implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. Regular resident meetings are held and residents are asked if they have any issues or concerns. The service completes a six-week post-admission survey for all residents</p>

<p>improvement principles.</p>		<p>where family input is included. Any issues that arise from these individual surveys or resident meetings are addressed accordingly using the corrective action process. The last resident and family satisfaction survey was undertaken in 2017.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>Both the care manager and the CNL described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. An up to date risk register is available to all staff.</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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported across all areas of the organisation to include staff, management and the board.</p> <p>The care manager and the CNL described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no police investigations, coroner's inquests or issues-based audits. A notification was made to public health related to a Noro-virus outbreak in November 2018. (Refer comments in section 3.5).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	<p>PA Low</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and performance reviews after an 11-week period and annual staff appraisals were up to date.</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>Continuing education is planned on an annual basis, including mandatory training requirements. There is no process in place to follow up on staff who do not complete annual mandatory training. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. (Refer comments in 1.3.3.3 related to interRAI timeframes).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. This was evident in the management report sighted which identified one newly admitted resident who was restless at night was managed by having an additional staff member on nights for four nights until the resident settled. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of a three weeks' rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All clinical staff hold current first aid certificates and there is 24/7 RN coverage at the facility.</p> <p>The CNL works eight hours Monday to Friday and is on call. The care manager works Monday to Friday and is on call. There are 52 activity hours one week and alternate weeks there are 60 activity hours. Dedicated cleaning staff work 78 hours per week, laundry staff 56 hours per week and kitchen hands 87.5 hours per week. The main kitchen staff are managed by the village. The administrator works 32.5 hours per week and receptionist 20 hours per week. A physiotherapy assistant works 16 hours per week.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when</p>

		<p>administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>One resident was self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by the village kitchen manager and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan. The kitchen was audited by the Auckland City Council in May 2018 and was awarded an A for excellent (100%) grade. Registration was issued and expires 17 May 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews on the day of audit. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and a high standard of care is provided. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care</p>

adequate and appropriate services in order to meet their assessed needs and desired outcomes.		provided and in accordance with the residents' needs.
<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 activities programme is provided by one trained diversional therapist holding the national Certificate in Diversional Therapy, and an activities co-ordinator also training to become a diversional therapist. Residents are supported by the activities team Monday to Friday 9.00 am to 4.00 pm, Saturdays and alternative Sundays 9.00 am to 1.00 pm.</p> <p>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 resident's activity needs are evaluated daily and as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions and residents' meetings. Residents and families interviewed on the day of audit confirmed they find the programme interactive and lots of fun.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for weight loss, wounds and infections. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate,</p>	FA	A current building warrant of fitness (expiry date 12 February 2020) was publicly displayed on at the entrance to the care unit. Residents and family members were happy with the environment.

<p>accessible physical environment and facilities that are fit for their purpose.</p>		
<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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastro enteritis and other infections. The IPC co-ordinator with the support of the clinical nurse leader reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Forty-three residents consented to the flu vaccine in April 2019.</p> <p>The facility has had a total of 75 infections from October 2018 through to and including March 2019. Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. There was evidence of over reporting of infections. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Benchmarking does not occur.</p> <p>A summary report for a recent gastrointestinal infection outbreak which occurred between 22 November 2018 and 2 December 2018 where nine residents and one staff member were affected was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. Policy states that enablers are the least restrictive devices, equipment or furniture voluntarily used by residents. The restraint coordinator provides support and oversight for enabler and restraint management in the facility as set out in the job description.</p> <p>On the day of audit, no residents were using restraints and eight residents were using bedside loop enablers, which did not restrict the residents' movement but had been put in place at the residents request to enable them to continue independence. The files reviewed for enabler use contained signed consent and all completed reviews and assessments. Enablers were identified on the resident's care plan.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>

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 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	The service has a documented process which includes regular collection, collation, review and reporting of quality data, complaints, restraint, health and safety and any other issues that may arise across all levels of the organisation. All quality achievements are measured against the strategic and business plans by the management group and board of trustees. One of the measures that is stated as attributing to the measure of achievement is a regular annual resident/family satisfaction surveys. This has not occurred since 2017. The service does use information gathered from residents’ meetings, multidisciplinary meetings and six-week post admission surveys to make improvements to the service.	The last documentation located related to a resident/family satisfaction survey is dated 2017 and the results of this survey had not been collated or analysed.	<p>Provide evidence that resident/family satisfaction surveys are undertaken at least yearly, and that the data is used to measure achievement against the quality and risk planning process as identified in policy.</p> <p>180 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to</p>	PA Low	The annual education plan identifies ongoing education which is presented at least monthly on-site by the CNL and guest speakers such as the gerontology nurse specialist from WDHB, physiotherapists and	Emergency management fire training is one of the	Provide evidence that staff who have not attended

<p>identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>specialist nurse practitioners, as appropriate. All education is recorded for individual staff but if a staff member does not complete the annual required compulsory education sessions this is not being followed up. The CNL confirmed during interview that the service recognised this as an issue and that the newly introduced electronic data base was commenced to address this.</p>	<p>required compulsory education sessions and in two of the six staff files reviewed there is no evidence of when the staff members last undertook this training following orientation.</p>	<p>compulsory annual education sessions are followed up to ensure compliance.</p> <p>180 days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>All residents have individual details and resident specific initial care plans and long-term care plans. Residents have an interRAI assessment completed by one of five trained interRAI assessors on site. Staff interviewed stated that they knew the residents well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process. The facility was able to show evidence of the three residents having had previous interRAI assessments; however, on the day of audit the three residents did not have an up to date interRAI assessment.</p>	<p>Three residents residing at the facility do not have an up to date interRAI assessment as was required in March 2019.</p>	<p>Provide evidence that all residents have an up to date interRAI assessment completed within the required timeframes.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.