# Bainfield Park Residential Care Limited - Bainfield Park Residential 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Bainfield Park Residential Care Limited

**Premises audited:** Bainfield Park Residential Home

**Services audited:** Residential disability services - Intellectual; Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services – Sensory

**Dates of audit:** Start date: 12 November 2019 End date: 12 November 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 |
|  | 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

Bainfield Park provides residential services for people with physical, intellectual and sensory disabilities and residents requiring rest home level care for up to 57 residents. There were 46 residents during the audit.

The unannounced surveillance audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of resident’s and staff files, observations and interviews with residents, relatives, staff and management.

The service is managed by an appropriately qualified and experienced general manager who has been in the role for two years. She is supported by a clinical nurse manager. There are quality systems and processes being implemented.

The previous shortfall around respite care planning has been addressed.

This audit identified shortfalls around minimising risks and wound documentation.

## 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. |

Open disclosure is maintained and evident with relatives’ notification documented on incident reports. A complaint register in maintained. Complaints are well managed.

## 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. |

A business and quality plan in being implemented. Quality data is collated and discussed at meetings. Internal audits are completed as scheduled. Satisfaction surveys show overall satisfaction with the service. An education plan is being implemented using an online system. Staff files reviewed evidenced good employment practices are adhered and include role-specific orientation. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and were reviewed at least six monthly. Resident files included medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered and enrolled nurses are responsible for the administration of medicines. Medications are reviewed three monthly by the general practitioner.

The activities coordinators implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Residents commented positively on the meals.

## 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. |

A current building warrant of fitness is in place. Regular reactive maintenance occurs, and preventative maintenance schedules are maintained. All communal areas are accessible to residents with mobility aids. External areas are well maintained and provide seating and shade.

## 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. |

Bainfield Park has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were six residents using an enabler. Assessments and consents were fully completed. Staff receive training around restraint minimisation.

## Infection prevention and control

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

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

## 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 | 16 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 41 | 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 | Complaint forms are available at the key points around the facility. The residents interviewed were aware of the complaints process, and where to access complaint forms.  A complaints register is maintained. Eight complaints have been lodged since the previous audit. Complaints were around staff interactions care. The advocacy services were involved with two of the complaints. The complaints were addressed in a timely fashion and were documented as resolved. Education sessions were provided to the staff members in a staff meeting, an external session at the DHB around communication, and an HDC study day. Compliments and complaints are discussed at the quality meetings. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Seven residents interviewed confirmed communication with staff was open and effective. The service has an open disclosure policy and staff interviewed confirmed their understanding of open disclosure. Any communication with family/whānau was documented in the residents’ progress notes. Ten incidents reviewed from across the service identified relatives were informed where required, or the reason for not notifying was documented. No relatives were available for interview during the audit. The residents stated they can go to the management team if they have any concerns.  Information provided meets the needs of those with intellectual, physical and sensory disabilities. Communication needs are documented in the residents’ care plans. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bainfield Park provides residential services for people with physical, intellectual and sensory disabilities; and residential services for older persons requiring rest home level care. The service is governed by a Trust with a board of directors that oversee the Trust.  On the day of the audit 46 of the 57 available beds were occupied. This included 9 rest home level residents (four residents on ARC, and five residents on a long-term chronic support- chronic health contract LCS-CHC). There were 29 residential disabilities residents (seven physical disabilities, and 22 intellectual disabilities). Three residents were funded under ACC, four were funded under the mental health, and one resident was on respite.  The general manager (GM) is a registered nurse. She has been in this role since September 2017. She has previous experience in mental health and aged care and has had a senior management role within the DHB. She is supported by a clinical nurse manager (CNM) who has been in the role for 13 years, registered nurses (RNs) enrolled nurses (ENs) and long-standing caregivers.  The 2019 to 2021 business and quality plan is being implemented. The general manager attends the two monthly board meetings and provides a formal report. There are frequent informal meetings and communication with the chairman of the board. Goals documented in the plan include refurbishments, moving to an electronic quality system, and promoting healthy lifestyles for residents. Goals are regularly reviewed as documented in the board and quality meetings.  The GM and CNM have maintained at least eight hours annually of professional development activities related to their roles at this facility including attending conferences and the clinical manager has attended an infection control conference. |
| 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. | FA | The manager oversees the quality programme. Quality portfolios have been developed and delegated to the shift supervisors (RNs and ENs). Two ENs are responsible for the completion of internal audits, collation of results and corrective actions. Monthly data is collated for infection control and adverse events. Corrective actions are documented on a quality form, these are either signed off as completed or continued as ongoing. Minutes of monthly quality meetings, staff meetings, and clinical RN/EN meetings evidence discussion of results, corrective actions and trends identified, and give staff an opportunity to suggest improvements to be made.  Bainfield Park is focusing on healthy lifestyles which is being led by the GM, CNM GP, Activities and the Kitchen. This is reducing the number of sweet options and providing healthy savoury options, increasing physical activities and frisbee golf has been set up in the grounds.  There is a health and safety officer who leads the health and safety programme and meetings. The hazard register is reviewed at each meeting. There is a walk around health and safety audit completed prior to each meeting. Meetings are held quarterly and are discussed at all other meetings. Health and safety training was last held in April 2019. There is health and safety training provided as part of the online education programme. All staff complete a health and safety quiz annually. Falls prevention strategies are also being implemented for residents.  Resident meetings are held three monthly, residents provide feedback and suggestions the have around activities and aspects of life at Bainfield Park. Annual resident and relative surveys are held using survey monkey. The 2018 relative survey evidenced an overall satisfaction rate of 46.6% very satisfied and 53.8% satisfied. The 2019 result showed an overall satisfaction rate of 82.3% very satisfied.  The 2018 resident satisfaction survey showed 89% satisfied with the dining experience and then following changes 100% satisfaction and 78% quick response to behaviours. The 2019 survey was in the process of being collated, provisional results showed 95% of residents felt safe, and 60% were very satisfied with staff interactions.  Initiatives made following a residents’ survey included (but not limited to); changing the dining room so residents feel safe around each other. There are two dining areas now, residents have a choice of where to dine, and were involved in choosing the names of the dining areas and setting them up. A further survey on food and dining evidenced a 100% satisfaction rate. |
| 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 Low | The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Ten incidents sampled for October and November, demonstrated appropriate documentation and clinical follow-up and have been reviewed by the CNM. Accidents and incidents are analysed monthly with results discussed at staff meetings, however, incident forms reviewed did not include documentation around minimising risks.  The management team are aware of situations that require statutory reporting. There have been four notifications made since the previous audit around residents’ behaviour. And one serious medication error. |
| 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. | FA | Five staff files sampled (one RN, one EN, one activities assistant, one caregiver, and one housekeeping) demonstrated appropriate employment practices and documentation. Current annual practicing certificates are kept on file. Two of the staff were recently employed and were completing their orientation. Three staff were employed within the last six months and the two long-term files had current appraisals completed.  The orientation package provides information and skills around working with residents with aged care and disabilities and was completed in all staff files sampled.  The CNM is interRAI trained. All RNs, ENs and activities staff have a current first aid certificate.  There is an online annual training plan in place which is being implemented. Residents and the family interviewed stated that staff are knowledgeable and skilled. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for staffing the services. There are two shift supervisors (RN/EN) rostered for the morning duty and one shift supervisor rostered for the pm shift and one shift supervisor rostered for the night shift. There is an on-call roster which is shared between the CNM and the three registered nurses.  Maitai wing 27 residents,; (4 rest home, 3 mental health, 1 ACC, 10 intellectual disability, 5 chronic health conditions, and 4 physical disability) is staffed with one shift supervisor and one caregiver from 7am to 3pm and one “float” from 10.30am to 9pm on the morning shift.  A shift supervisor is rostered from 2.45pm to 11.15pm with one caregiver from 2.45 to 11pm and one caregiver from 4pm to 9pm.  Kiwi wing with 19 residents including one resident in a flat and 4 residents in the annex (12 intellectual disability, 3 physical disability, 1 mental health, 2 on ACC, 1 respite) is staffed with one shift supervisor and a short shift care assistant (7.00 am – 1.00 pm). The PM shift is staffed with one care assistant and a shift supervisor who is also covering Maitai wing.  Activities staff are rostered Monday – Friday from 9.00 am – 4.30 pm Saturday and Sunday 0900-1500 with an additional volunteer assisting with men’s activities one day a week.  Staff, residents and relatives interviewed confirmed that staffing levels are adequate. Residents confirmed that their call bell is answered in a timely manner. |
| 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 | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders. There are no vaccines stored on site.  The facility uses an electronic and medico pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and ENs administer all medications. There is a list of senior medication competent caregivers who are permitted to check medications with RNs/ENs. Staff attend annual education and have an annual medication competency completed. Two RNs are syringe driver trained by the hospice. The medication fridge and room temperatures are checked weekly. Eye drops are dated once opened.  Staff sign for the administration of medications on the electronic system. Fourteen medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. ‘As required’ medications had indications for use charted. |
| 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 service has a kitchen supervisor and two cooks who cover the week between them. There are four rostered kitchenhands. All cooks have current food safety certificates. The kitchen manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are kept warm in a bain marie and then transported on trollies. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents’ dietary needs have been communicated to the kitchen. The four weekly summer and winter rotating menu plans are approved by a dietitian. All residents interviewed were satisfied with the meals.  The food control plan was verified on 1 September 2019. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | An initial assessment is completed on admission. InterRAI assessments are completed within the required timeframe and link to the care plans. Residents and family are involved in assessment. Returning respite residents have a reassessment on each admission and care plans are updated as required. A previous finding in this area has now been closed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident’s condition changes the RN/EN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative’s health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents’ needs changed.  Resident falls are reported on accident forms and written in the progress notes. Neurological observations are taken when there is a head ‘knock’ or for an unwitnessed fall.  Caregivers interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.  There was no documented evidence of wound assessment, and wound evaluation other than in a short-term care plan. There is no wound register, so it is difficult to ascertain how many wounds are currently being treated and staff appeared unsure. There is currently one stage four pressure injury. Pressure injury equipment is available.  Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. |
| 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 | There is one activities coordinator who works 24 hours a week plus two hours a week for one-on-one exercises. There are 2 other activity co-ordinators one works 16 hrs a week and the other in weekends for 10 hours a week. All work across all areas. There is also a volunteer who comes every Tuesday to read stories and do craft. On the day of audit residents were observed making lemon cupcakes and participating in a karaoke session. Six residents with intellectual disabilities were out at work.  There is a weekly programme in large print on noticeboards in all areas and some residents like to keep a copy in their rooms. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents’ needs. These include exercises, bingo, news from the paper, music, quizzes, crafts, cooking and games.  Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.  There is a weekly interdenominational church service and also Catholic communion as required.  There are weekly van outings. If there are social events on in town, residents are taken in the van. There are pet therapy visits and there is a lot of bird life in the nearby bush to observe including ducks. Special events like birthdays, Easter, Mothers’ Day, Anzac Day, and Melbourne Cup are celebrated. Entertainers visit weekly.  There are strong links with the community. As well as those who go out to work, independent residents go out for coffee and/or lunch. Some residents go to art classes, movies shopping and concerts. Some residents go to the Blind Foundation weekly and some mental health residents attend Rata House mental health day programme. Rata House also comes in and plays bowls monthly.  Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly.  Resident meetings are held three monthly and there are annual satisfaction surveys. Residents interviewed were happy with the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Except for the respite resident, all care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short- term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan. |
| 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 holds a current warrant of fitness which expires 3 February 2020.  Electrical equipment has been tested and tagged. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges, hallways and bedrooms are spacious and allow room for residents to move around with mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.  Caregivers interviewed stated they have adequate equipment to safely deliver care. |
| 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 | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (CNM) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed at quality, health and safety, RN and staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint minimisation policy in place. The facility has no restraints and only six enablers. There are currently six enablers. All are lap belts on wheelchairs and residents are able to undo them. They are all used for safety reasons only. They are documented in the resident’s care plans. Consent for enabler use has been signed. Restraint education takes place annually on the online system. There is a restraint coordinator. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | There is a restraint minimisation policy in place. The facility has no restraints and only six enablers. There are currently six enablers. All are lap belts on wheelchairs and residents are able to undo them. They are all used for safety reasons only. They are documented in the resident’s care plans. Consent for enabler use has been signed. Restraint education takes place annually on the online system. There is a restraint coordinator. |

# 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 1.2.4.3  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 Low | Incident reports are completed following all adverse events. All forms were completed by the first on the scene and evidence clinical follow-up. The incident reports were reviewed and signed off by the clinical nurse manager and discussed at meetings, however they do not evidence opportunities to minimise risks. | Ten of ten incident reports reviewed did not evidence opportunities to minimise risks. | Ensure opportunities to minimise risks are identified where possible and documented on the incident reports.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Wounds are currently written up in a short-term care plan, which outlines the wound management. There was no documented evidence of wound assessment, and wound evaluation. The facility has a wound assessment form, but this was not in use. There were no photos of a wound’s progress. There was input from a wound care nurse specialist when required. | There was no wound register. There was no documented evidence of wound assessment and wound evaluation. | Commence a wound register and ensure wound assessment and wound evaluation forms are in place.  180 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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End of the report.