

# The Ultimate Care Group Limited - Ultimate Care Churtonleigh

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## Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	The Ultimate Care Group Limited	
<b>Premises audited:</b>	Ultimate Care Churtonleigh	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 4 February 2020	End date: 5 February 2020
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	31	

# Executive summary of the audit

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

## General overview of the audit

The Ultimate Care Group Limited - Ultimate Care Churtonleigh is certified to provide care for 36 residents at rest home and hospital levels of care. There were 31 residents at the facility on the first day of the audit.

This surveillance audit was conducted against the relevant Health and Disability Service Standards and the service contract with the district health board.

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

There were no areas requiring improvement at the previous certification audit.

There are areas identified as requiring improvement at this audit relating to: corrective action plans; unwitnessed falls and staff performance reviews.

## 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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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights is made available to residents and family on the resident's admission and at the facility.

Open communication between staff, residents and families is conducted. There is access to formal interpreting services if required.

Residents, family and the general practitioner's interviews confirmed that the environment is conducive to communication, including identification of any issues.

There is a documented complaints management system and a complaints register is maintained. Complaints are investigated and documented, with corrective actions implemented where required.

## 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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The Ultimate Care Group Limited is the governing body responsible for the services provided at Ultimate Care Churtonleigh. The mission and values of the organisation are documented and communicated to all concerned.

The facility is managed by an appropriately qualified and experienced facility manager. A clinical services manager provides oversight of clinical service provision and is supported by a team of registered nurses. The management team is supported by the Ultimate Care Group regional manager.


The Ultimate Care Group Limited's quality and risk management system is implemented and supports the provision of clinical care and quality improvement within the facility. Policies and procedures are reviewed and current. There is reporting of service delivery data and related indicators by the facility manager to the national support office for the monitoring of service delivery within the facility.

Adverse events are documented and where required corrective actions are implemented. Actual and potential risks, including health and safety risks, are identified and mitigated.

New staff undertake orientation appropriate to their role. Practising certificates for staff and contractors who require them are validated annually. An annual training programme is implemented.

A review of rosters and staff, resident and family interviews confirmed that there is adequate staff available.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents' files reviewed evidenced risk assessments and initial care plans were completed on admission. Desired outcomes and goals of residents were documented in files reviewed. The general practitioner documentation included regular reviews and timely interventions. The general practitioner reported that the clinical team were competent. The general practitioner stated there is regular communication and family are invited to participate in general practitioner reviews, including three monthly reviews. Family communication is documented in the resident's clinical file. Residents' progress notes and observation charts are maintained. Clinical handovers occur at the beginning of each shift.

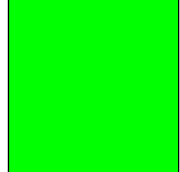
All interRAI assessments in files reviewed were completed within the required timeframes. There was evidence the interRAI informs the long-term care plan.

The planned activities are provided by a diversional therapist and assistant on a one-on-one basis and in group settings. The residents interviewed indicated satisfaction with the activities programme.

An appropriate medication management system is in place. There is a current medication competency register for staff responsible for administration of medications. In-service education sessions are provided for all staff responsible for medication management and administration.

Food and nutritional needs of residents are delivered in line with accepted nutritional guidelines. A central kitchen and on-site staff provide the food service. Records of staff training validated completion of food safety training. The food control plan is current.

## 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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Ultimate Care Churtonleigh has a current building warrant of fitness displayed in the facility. There have been no alterations or additions to the buildings at this facility since the last audit.

## 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 service uses facility policies and procedures to meet the standards for restraint minimisation and enabler use. Review of the documents and an interview with the restraint coordinator confirmed there are systems in place to ensure enabler use is voluntary. Assessments were undertaken prior to enabler use. The use of enablers was documented in the residents' care plans.

## Infection prevention and control

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

Staff are familiar with infection control measures. New employees are provided with training in infection control.

The infection control surveillance data confirmed the surveillance programme is appropriate for the facility. Surveillance of infections includes collation of data, analysis and benchmarking within Ultimate Care Group.

## 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)
<b>Standards</b>	0	13	0	3	0	0	0
<b>Criteria</b>	0	36	0	2	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 organisation has a complaints policy and process to ensure that complaints are managed in line with Right 10 of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code). The complaints information is included in the welcome pack provided to residents and their families on admission to the facility. Complaint forms are available within the facility.</p> <p>Residents’ and family interviews confirmed awareness of the complaints process and their right to advocacy services.</p> <p>The facility manager (FM) is responsible for complaints management. Complaints reviewed demonstrated that complaints are responded to within the required timeframes, investigated, corrective actions implemented and closed out when resolved.</p> <p>The FM stated there had not been any complaints to external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>The open disclosure policy is documented and implemented. Accident/incident forms, residents’ clinical records and resident and family interviews confirmed that information is shared whenever a resident has an accident/incident; a change in health status or a change in their needs level. Family contact is recorded on accident/incident forms and in residents’ clinical records.</p>

<p>conducive to effective communication.</p>		<p>Resident and family meetings inform residents and their family of events and activities, as confirmed in review of the residents' and family meeting minutes. The facility produces a newsletter to inform residents and family of past and future events and the facility's news. Residents and family members confirmed that they are kept informed and communication is appropriate.</p> <p>Interpreter services are available, when this is required.</p>
<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>	<p>FA</p>	<p>The Ultimate Care Group Limited (UCG) mission and values of the organisation are documented and communicated to all concerned through the facility's information pack provided to residents and their families on admission to the facility. New staff receive this information at their orientation.</p> <p>Ultimate Care Churtonleigh (Churtonleigh) is part of UCG. The organisation's direction and goals are documented and reviewed by national, regional and facility management. The Churtonleigh FM reports to a regional manager. The regional manager provided support to the facility during this surveillance audit.</p> <p>The executive management team at the UCG national support office receive monthly progress reports against identified indicators from the FM. Benchmarking against other UCG facilities occurs at a national level.</p> <p>The FM has been in this role for approximately three years and has past experience as a registered nurse (RN), however does not hold a current practising certificate. The FM is supported by a clinical services manager (CSM) who has been in the role for approximately two years. Prior to this role, the CSM worked in aged residential care as an RN and CSM at other aged care facilities. The CSM is supported by a team of RNs and the regional manager.</p> <p>The facility is certified to provide rest home and hospital levels of care for up to 36 residents. The facility has two apartments certified for rest home level of care only and the rest of the residents' rooms are dual purpose rooms. There were 31 beds occupied on the first day of the audit. Occupancy included: 20 residents requiring rest home level care and 11 residents requiring hospital level care. These numbers included: three rest home level respite care residents. The facility holds contracts with the district health board (DHB) for aged related residential care contract for rest home, hospital care and respite care. The facility does not have occupational right agreements.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>PA Low</p>	<p>The quality and risk management system is accessed by staff and management to guide service delivery at the facility.</p> <p>The national UCG management group reviews all policies with input from relevant personnel. Policies and procedures align with the Health and Disability Services Standards (refer to 1.2.4.3). New and</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>revised policies are presented to staff and staff interviews confirmed that they are made aware of new and updated policies.</p> <p>Internal audits are completed according to the UCG schedule, however; corrective actions, evidence of implementation of the corrective actions and sign off, are not always documented. Facility meetings occur as per the meeting schedule. Quality data is discussed at staff meetings. However, some meeting minutes do not reflect all areas of quality improvement information required.</p> <p>Satisfaction surveys are completed annually. Resident and family satisfaction surveys results for 2019 show overall satisfaction with the facility. The corrective actions required from the 2019 satisfaction survey are in a process of being written, confirmed at FM and regional manager interviews.</p> <p>Health and safety policies and procedures are documented along with a hazard management programme. Staff interviews confirmed an awareness of health and safety processes and their responsibilities to report hazards, accidents and incidents promptly.</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>PA Low</p>	<p>The management team are aware of situations which require reporting to statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. These are reported to the appropriate authority via UCG national support office staff. Since the previous audit the appointment of the CSM and one resident event had been notified to the HealthCERT (both section 31 were sighted).</p> <p>There is an adverse event reporting process and evidence adverse events are reported. A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms, which are signed off by the FM or the CSM. Information is also entered on the UCG electronic database of accidents/incidents. All accident/incidents reviewed demonstrated that the resident's family had been notified. This was confirmed in family and resident interviews.</p> <p>Staff interviews confirmed that staff receive education at orientation and in the staff training programme on accident/incident reporting processes and they are aware of their responsibility to report adverse events.</p> <p>Accident/incident reports reviewed evidenced that where a resident had sustained an injury or a fall for example; the RN had undertaken a physical assessment of the resident, such as a skin assessment, a falls assessment, blood pressure and neurological assessment where appropriate. However, neurological observations did not reflect best practice.</p>
<p>Standard 1.2.7: Human</p>	<p>PA Low</p>	<p>Human resource management policies and procedures are documented and meet the requirements of</p>

<p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; a position specific job description; a signed employment agreement and, where required, a valid work visa.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff and contractors that required them.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. Care givers (CG) are buddied with an experienced staff member until they demonstrate competency on specific tasks, for example: resident cares; hand hygiene; moving and handling.</p> <p>The CSM and two other RNs have completed interRAI assessments training and competencies. Two RNs are currently undergoing interRAI training.</p> <p>There is an annual education and training schedule, that includes topics relevant to the levels of care provided. Education session attendance records evidence that ongoing education is provided relevant to the services delivered. Interviews and training records sampled confirmed that staff undertake at least eight hours of relevant education per year.</p> <p>Staff who have been employed for less than one year had completed an orientation review three months post commencement of their employment. Not all staff files reviewed evidenced that staff employed for greater than one year have completed a current performance appraisal.</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>The facility's staff rosters are planned to ensure the residents' care requirements are met. There are RNs and CG available to maintain the rosters for the provision of care. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy. There is a RN on each shift seven days per week, supported by CGs on morning, afternoon and night shifts.</p> <p>The FM and CSM work on morning shifts and share on call after hours, seven days a week. Observation of service delivery confirmed that residents' needs are being met. Resident, family and general practitioner (GP) interviews stated that they noticed staff to be busy at times, but felt resident needs are being met.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines</p>	<p>FA</p>	<p>The medication storage room included and evidenced, drug storage and a secure medicine dispensing system in accordance with legislation and standards. Medications are stored in their original dispensed packs in secure trolleys.</p>

<p>in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>The drug register is maintained and evidenced weekly checks, and six-monthly physical and pharmacist stocktakes. The medication fridge temperatures are monitored and recorded.</p> <p>Staff authorised to administer medications have current competencies. The medication round was observed and evidenced the staff member was knowledgeable about the medication administered. Protocols and procedures were followed.</p> <p>Electronic medication charts evidenced current resident's photograph identification. The regular medications for each resident are recorded, including the name of the medication, dose, frequency and route.</p> <p>As required (PRN) medication, indications for use and maximum doses were recorded. Allergies were recorded and three- monthly reviews were conducted by the GP.</p> <p>There were no residents self -administering medications at the time of the on-site audit. A policy is in place should a resident be assessed as able to self-medicate.</p> <p>Residents who are in the facility for respite care have an individual folder and a paper chart. The medications are recorded and signed for by the individual resident's GP. The regular and PRN medications are signed as administered on a signing sheet by an authorised staff member.</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 facility has an on-site kitchen and staff to provide the food service. Menus are reviewed six-monthly and there was evidence of dietitian input.</p> <p>The residents' dietary requirements are identified on admission, documented and communicated to kitchen staff. The cook and kitchen staff interviewed confirmed they were aware of the resident's individual dietary requirements. Residents' dietary needs were reviewed as required if there was a change in a resident's need or health status as identified at staff interviews.</p> <p>The residents' files evidenced monthly recording of individual resident's weight. In interviews residents stated they were satisfied with the food service and their individual dietary preferences were met. The residents stated there were adequate amounts of food and fluids. Residents are provided with the opportunity to feed back on the food service at resident meetings and through resident surveys. Adequate crockery and specialised equipment for residents who required this was evidenced.</p> <p>Nutritional supplements made up in the kitchen evidenced expiry dates were recorded. Decanted food is dated and expiry dates are documented. Food temperatures are recorded. The fridges, chillers and freezer temperatures are monitored and documented, including fridges in residents' rooms and lounges. The kitchen was observed to be clean and fit for purpose. Hand washing equipment, gloves and hats were available. There was evidence of a maintained kitchen cleaning roster.</p>

		Food safety training and the food safety plan was recorded and current.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The resident's care plans evidenced interventions based on assessed needs and individualised desired outcomes.</p> <p>Interviews with residents and families confirmed the care and treatment delivered met their needs. Contact and links to community services are maintained. Staff interviewed evidenced familiarity with the needs of the residents they were allocated to. Family communication is recorded in the resident's file. Progress notes, GP records and observation charts reviewed were current.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A divisional therapist (DT) and one assistant provide a total of twelve hours planned activities per week. There is one activities programme which includes rest home and hospital residents. The activities programme is reviewed and updated monthly. An activities meeting is held quarterly and includes input from the DT, RN and other clinical staff.</p> <p>There are several areas throughout the facility where recreational activities are provided. The programme includes daily exercises, cognitive, social, and one-on-one and group activities. Religious events are celebrated and external agencies are incorporated into the programme. Residents are encouraged to attend but the activities programme is voluntary.</p> <p>There are current individualised activities assessments and care plans, as evidenced in the residents' files.</p> <p>Feedback is encouraged from family and residents at monthly residents' meetings. Interviews with residents confirmed satisfaction with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents files evidenced care planning evaluations are documented and implemented. The resident's care plans were current and reviewed six-monthly.</p> <p>There was evidence of resident, family, RN, CG, allied health and GP input into the care plan evaluations. Interviews with families confirmed they are informed of sudden changes in health status and they participate in care plan evaluations and GP reviews.</p> <p>Wound care plans evidenced timely and current evaluations. Resident's progress notes were entered on each shift. When a resident's health status changed there was evidence of GP and family communication. Short-term care plans are in place for acute health issues. Short-term care plans are signed off when the problem is resolved or added to the long-term care plan if ongoing. There was</p>

		evidence of additional input from other health professionals and specialists if required.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The facility has a current building warrant of fitness on display. There have been no structural additions or alterations to the facility's buildings since last audit.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control coordinator (ICC) is responsible for the surveillance programme at the facility. Monthly analysis is completed and reported at monthly clinical meetings.</p> <p>The surveillance is appropriate to the size and complexity of the service. Infection logs are maintained for all infections.</p> <p>Residents' files evidenced when a resident is identified as having an infection, this is documented in short-term care plans, progress notes and verbal handovers to inform staff.</p> <p>The ICC confirmed there has been one respiratory outbreak since the last audit. The outbreak was confined and managed according to the facility's policy and procedure the GP and DHB were kept up to date.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint and enabler policy was current and available to guide practice. Restraint is overseen by a restraint coordinator who is the CSM. The restraint meetings are held every three months and education to update staff is provided.</p> <p>No restraints were in use at the time of audit. There were two residents who had voluntary enablers in use (bed rail and lap belt). The individual residents' enabler assessments were reviewed and there was documented evidence of residents' giving voluntary consent. There is evidence of input from the GP, allied health, and family and care staff. The enabler use is reviewed and documented in the residents' care plans.</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 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>There was evidence the internal audits are completed as per the UCG internal audit schedule. The internal audit results are entered onto a computerised management system by the FM and/or the CSM to inform the UCG national support office of audit results within the facility.</p> <p>Review of the hard copy internal audits identified that where corrective action was required, this is not always documented and that evidence of the corrective actions implemented was not always recorded. The hard copy data did not consistently evidence when corrective actions were documented, that actions were signed off as completed.</p> <p>Review of the facility’s meeting minutes evidenced internal audits are raised at the meetings, however; the detail of the internal audit results and corrective actions required were not documented in the minutes of meetings. The data recorded included number of partial attainments at an audit, however, the detail of the findings and the corrective action required was not documented. A staff member who was not present at the meeting and was reading the meeting minutes to inform themselves, would not gain</p>	Internal audits do not consistently evidence corrective actions and sign off and this is not always communicated to staff.	<p>Provide evidence corrective actions required following internal audit are documented, completed, signed off and communicated to all concerned.</p> <p>180 days</p>



		understanding from the level of detail recorded in the minutes.		
<p>Criterion 1.2.4.3</p> <p>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.</p>	<p>PA Moderate</p>	<p>There was evidence of accident/incident forms completed for adverse events that had occurred. Next of kin are notified of residents' accidents/incidents as documented on the accident/incident forms and in residents' progress notes.</p> <p>Assessments and observations are undertaken where residents have experienced a fall. Review of residents fall information evidenced that neurological observations were not always undertaken. Where they were undertaken, they were not conducted for the recommended timeframes in accordance with best practice.</p>	<p>i) The policy and procedure for neurological observations following an unwitnessed fall does not align with best practice.</p> <p>ii) Neurological observations are not completed consistently for all unwitnessed falls.</p>	<p>i) Ensure the policy and procedure for neurological observations following an unwitnessed fall aligns with best practice.</p> <p>ii) Ensure neurological observations are completed for all unwitnessed falls.</p> <p>30 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>There is a system in place for staff training and records confirmed staff education is planned and facilitated.</p> <p>Performance reviews are conducted three months post a staff member's commencement of employment at the facility. Review of six staff files evidenced two staff, who had been employed for more than one year, did not have current performance reviews.</p>	<p>Not all staff have current performance reviews completed.</p>	<p>Provide evidence all staff have current performance reviews conducted annually.</p> <p>365 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.