Graceful Home Limited - Rose Lodge Rest 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 HealthShare 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:	Graceful Home Limited
Premises audited:	Rose Lodge Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 31 August 2020 End date: 31 August 2020

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: 11

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

Graceful Home Limited, trading as Rose Lodge Rest Home, provides rest home level care for up to a maximum of fourteen residents. Short stay /respite can also be provided subject to bed availability. The home is privately owned and operated by a managing director who operates two other aged care facilities in Auckland. A registered nurse (RN) and team leader provide day to day management and clinical oversight with input from the managing director who oversees staffing, building, grounds, equipment, and procurement. There have not been any changes to the organisation since the last audit.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included a review of relevant policies and procedures; a review of resident and staff files; observations; and interviews with residents, family, management, and staff.

The improvements required at the previous audit relating to storage and accessibility of archived records, menus and to internal and external repairs to the physical environment were fully implemented.

This audit identified that improvements are required around the quality programme, training, and to the activities programme.

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.

Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed they are provided with adequate information and that communication is open. Family members stated that they are informed of any change of care or incident related to their family member.

Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints with these investigated in a timely manner.

Organisational management

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

The quality management system describes quality improvement processes. Progress with the quality management programme is expected to be monitored through the three-monthly quality/health and safety/infection control meetings. Data is collected on complaints, accidents, incidents, infection control and restraint use. Resident/relative meetings are held every three months. There are human resources processes including recruitment, job descriptions, selection, orientation and staff training and development.

The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care for rest home 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 medium or high risk and/or unattained and of low risk.

Assessments are completed in a timely manner by suitably qualified personnel. Residents are referred or transferred to other health services as required. The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

Medicines are administered by competent staff. Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

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

The building has a current warrant of fitness. The indoor and outdoor environment meets the needs of the residents. Electrical and medical equipment is tested as required.

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.

Rose Lodge Rest Home has restraint minimisation and safe practice policies and procedures in place. There are no residents requiring the use of restraints or enablers. Staff receive training in restraint minimisation.

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.

The infection prevention and control programme led by a trained infection control coordinator aims to prevent and manage infections. The programme was reviewed annually. Specialist infection prevention and control advice was accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance was undertaken, and results reported through all levels of the organisation. Follow-up action was taken as and when required. There were no infection outbreaks reported since the last audit.

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	2	2	0	0
Criteria	0	40	0	2	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms met the requirements of Right 10 of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed said they felt comfortable and would not hesitate to raise a concern if they had one. There are no complaints documented on the complaints register since 2018. The staff confirmed that residents did not complain and that concerns raised were dealt with at the time the issue was raised. The clinical nurse manager could describe the formal response process as per policy. The director is responsible for complaints management and follow up. All staff interviewed confirmed a good understanding of the complaint process and what actions are required. There have been no complaints to the Health and Disability Commissioner (HDC) nor any requests for advocacy services to provide support for residents' in the past year.
Standard 1.1.9: Communication Service providers communicate effectively	FA	Residents and family/whanau reported that they are accorded the right to full and frank information or open disclosure. The environment is conducive to effective communication and interpreter services are provided if required. Policies and procedures are in place if the interpreter services are needed to be accessed. Staff education had been provided related to appropriate communication methods from individual residents. One

with consumers and provide an environment conducive to effective communication.		resident who is nonverbal is able to communicate effectively with staff through body language and verbal expressions. Documentation regarding open disclosure following incidents/accidents was evident through documentation and with family interviewed confirming this.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The business/quality/risk and management plan ending 2019 was reviewed in August 2020 by the clinical nurse manager with support from the District Health Board (DHB). A new business/quality/risk and management plan February 2020 has been documented. This outlines the purpose, values, scope, and direction of the organisation. The mission statement and philosophy is also documented. This also contains detailed annual and longer-term goals. The managing director monitors progress against the business plan and is now involving the group management team at six weekly meetings. External advisors such as a quality consultant, and accountant are consulted and/or provide support services to the business. The director has owned and operated Rose Lodge since 2014 and also operates two other aged care facilities which provide specialist dementia care. The director visits the site once or twice a week. The director is expected to meet with the managers of the three facilities monthly noting that this is a new initiative and has only occurred to March 2020 and then stopped when Covid-19 level four was put in place. The service holds contracts with the Ministry of Health and Auckland DHB, for rest home level care, long term support-Chronic Health Conditions and residential respite services. On the days of audit, 11 of the maximum 14 beds were occupied. Ten of the residents are under the Age-Related Care Contract. Residents under the ARCC are not under 65 years. There was one additional person of a similar age to the other residents living in the main house as a boarder under agreement with the owner. This is a long-term arrangement and staff are continuing with their attempts to have the residents needs assessed. The clinical nurse manager provides day to day operational management of the service and has 31 years' experience in nursing, with a background of working in women's health and other District Health Board roles for 10 years. The clinical nurse manager has been in the service for one year and is currently completing the post graduate diploma in nursing.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented,	PA Low	Rose Lodge Rest Home has an established quality and risk management systems which includes policies and procedures that guide current accepted practice. An organisational risk management plan is documented and reviewed annually. The policies used are a generic system moderated by an external quality consultant and these 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 have been reviewed in 2020. The document control system ensures a systematic and regular review process, referencing of relevant

and maintained quality and risk management system that reflects continuous quality improvement principles.		sources, approval, distribution, and removal of obsolete documents. Review of the business, quality, and risk management plan evidence that this is updated annually or as required. Service delivery and organisational performance is expected to be monitored by internal audits and resident and family feedback. Audits have been completed to April 2020 noting that during the lockdown period, there was a focus on providing care and day to day support for residents in the service. Meetings are expected to be held monthly however these have not been held at frequent intervals in 2019 or in 2020 (noting that during level four, there was a directive from the Ministry of Health to not hold meetings face to face). There is a small team of staff and staff talk informally as well as through meetings to handover any issues. When meetings are held, then analysis of complaints, incidents and accidents and infections are considered to identify issues or changes required. Review of documents, observations, and interviews confirmed that the clinical nurse manager and staff respond to matters that require improvement by implementing corrective actions as soon as practicable. The comprehensive risk management programme includes health and safety policies and procedures and a current hazard register. Health and safety audits occur regularly. The documents sampled confirmed that any issues identified are documented in a corrective action plan and signed off when resolved. Hazards identified are risk rated, eliminated, minimised, or isolated, and documented in the register. The clinical nurse manager confirmed that staff understand the importance of identifying any issues as soon as these arise so these can be fixed immediately. Review of meeting minutes confirmed that health and safety, hazards and management of any other risks is discussed at staff meetings when these are held. The clinical nurse manager and staff were aware of their roles and responsibilities under the Health and Safety at Work Act. The annual resident/family satisfaction survey only had one resident who completed the questionnaire. They were satisfied with the service provided. Four staff responded to the staff survey in 2020 and they were happy with all aspects of work.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	Staff document all adverse and near miss events on accident/incident forms. The sample of forms reviewed for May to August 2020 were consistent in clearly describing and detailing the incident and recording who had been notified. There have been very few incidents (for example, 12 incidents year to date in 2020). The clinical nurse manager reviews all incidents/accidents and investigates, as necessary. Each incident form sampled contained a management comment or preventative action for closure or follow-up. The clinical nurse manager demonstrated understanding about essential notification reporting requirements, including for pressure injuries. It was reported that there have been no events requiring notification to the Ministry of Health, or the DHB since the previous audit apart from notification to the Ministry of the change in clinical nurse manager in July 2019.

		An improvement is required regarding the recording of observations following an unwitnessed fall.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, validation of qualifications and practising certificates (APCs) where required. Copies of practising certificates for the registered health practitioners are on file. The required staff recruitment documents were sighted in staff records sampled. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well. The personnel records sampled included documentation of completed orientation, competency assessments and a performance reviews. Individual personnel records are being updated as required. Continuing education is planned on an annual basis and is expected to occur each month with the 2020 schedule in place. There were only two training sessions provided in 2019 despite monthly topics being documented on the schedule. In 2020, the training schedule has been partially implemented with training for staff on Covid-19 in June 2020. Attendance registers are kept with evidence that all staff attended training sessions when these are offered. There are three new staff who have joined the service in 2020. The health care assistants (HCAs) who have been with the service for over two years have achieved qualifications related to care of older people. Each of the staff records sampled confirmed attendance at ongoing training and completion of annual performance appraisals. The registered nurse is trained to undertake interRAI assessments. The clinical nurse manager at a sister facility (who has been in their role for four years) is also interRAI trained and can provide support and mentorship when required. There are a total of 11 staff including the director, clinical nurse manager, six health care assistants, maintenance staff, cook, administrator. The current clinical nurse manager has resigned from the 18 August 2020 with the final day on site on the 1 September 2020. The clinical nurse manager stated that another nurse is expected to come for orientation tomorrow and the clinical nurse manager at another facility is able to provide cover and support. An improvement is required regarding implementation of the training schedule.
Standard 1.2.8: Service Provider Availability	FA	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 (4/7). There is a health care assistant on duty on each shift with a handover between shifts. Observations and review of the monthly roster confirmed adequate staff

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		cover has been provided, with staff replaced in any unplanned absence. All staff have current first aid certificates. The clinical nurse manager and the staff interviewed stated that staffing levels are adjusted to meet the changing needs of residents. The director is available after hours and the clinical nurse manager is on call at all times. Staff stated that ready access to advice is available when needed. All the staff interviewed said they had enough time on each shift to complete the work allocated to them. The residents and family interviewed expressed satisfaction with the availability of staff.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All resident records sighted were in hard copies. Residents' records sighted were integrated. Progress notes were completed daily by care staff and weekly by the clinical nurse manager. Appropriate documentation requirements were met. No personal or private resident information was on public display during the audit, they were stored securely in the locked cupboard. The previous requirement regarding the storage and accessibility of archived records has been addressed. Staff interviewed were able to describe information being kept in a confidential 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	Rose Lodge Rest Home uses a paper-based medication management system that was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines were competent to perform the function they manage, and current medication administration competencies were sighted in staff files reviewed. Medications were 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 was provided on request. Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for as required (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders were not used. There were no residents who were self-administering medications at the time of audit.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service was provided on site by a qualified Cook and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in March 2019. Recommendations made at that time have been implemented. 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 and registration issued by the Ministry of Primary Industries (MPI). A food services verification audit was completed in July 2020 and recommendations made were implemented. Food temperatures are monitored appropriately and recorded as part of the plan. The cook has completed a safe food handling qualification, with the HCAs completing relevant food handling training. A nutritional assessment was 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. Special equipment, to meet resident's nutritional needs, was available. Evidence of residents' satisfaction with meals was verified by residents and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. The previous areas of improvement regarding the menu review by a registered dietitian and registration of the food services with a recognised organisation to meet the requirements of the Food Act (2014) regulations were addressed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations, and interviews verified that 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 interviewed GP verified that medical input was sought in a timely manner, that medical orders are followed, and care is implemented in a timely manner. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	PA Moderate	A social assessment and history was undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments were regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs were evaluated as part of the formal six-monthly care plan reviews. Activities reflected residents' goals, ordinary patterns of life and included normal community activities.

requirements are appropriate to their needs, age, culture, and the setting of the service.		Residents and families/whānau were involved in evaluating and improving the programme through residents' meetings. The interviewed residents confirmed they find the programme when it is available and being provided. One on one activities (very limited) and group activities were not being provided since April 2020.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care was evaluated on each shift and reported in the progress notes by the health care assistant (HCA). Any change noted was reported to the CNM. The CNM documented in the progress notes at least once a week. Formal long-care plan evaluations occurred every six months following the six-monthly interRAI reassessment, or as residents' needs change. Where progress was different from expected, the service responded by initiating changes to the plan of care. Short-term care plans were completed for acute infections and evaluated as clinically indicated. The short -term care plans were closed off when the acute conditions resolved. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Rose Lodge Rest Home premises are leased from a private landlord and Graceful Home Limited is responsible for the repairs and maintenance of internal fixtures and fittings. A current building warrant of fitness was displayed. There have been no building modifications since the previous audit. Inspection of all interior and exterior spaces revealed that three areas that required remedial work had been addressed. This included repairs to a toilet and to previous slippery ramps. Reactive maintenance is carried out by staff or certified tradespeople where required. Documents confirmed that medical equipment (for example, thermometer, weighing scales and blood pressure equipment) has been checked and calibrated recently by an external company and all plug-in electrical appliances were tested and tagged by an authorised person this year. Staff interviewed confirmed they have ready access to suitable equipment. There is an approved evacuation plan and evacuation drills that occur six monthly. There is easy access to plenty of safe and shaded seating areas outside for residents. Visual inspection confirmed the service vehicle used for transporting residents has a current warrant of fitness and registration.
Standard 3.5: Surveillance	FA	Surveillance of infections was carried out as specified in the infection control programme. Surveillance was appropriate to that recommended for long term care facilities and included infections of the urinary tract,

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		cellulitis, eye, gastro-intestinal, the upper and lower respiratory tract. The infection control coordinator reviews all reported infections, and these were documented. New infections and any required management plans were discussed at handover, to ensure early intervention occurs, interviewed staff confirmed this. Monthly surveillance data was collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared at staff handovers, (link 1.2.3.6). Graphs were produced that identify trends for the current year, and comparisons against previous years and this was reported to the director/owner. The reviewed records evidenced that infection rates in the facility are minimal. Appropriate infection control strategies and recommendations from the Ministry of health in regard to the current COVID-19 pandemic management were in place.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Rose lodge Rest Home is a restraint free facility. Policies and procedures met the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers should this be required. The CNM has the overall responsibility in assessing and providing guidance for restraint or enabler use, if required. Staff receive training in restraint minimisation and safe practice standards as well challenging behaviour management. On the day of audit, there were no residents using restraints nor enablers.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality data is expected to be collected through incidents, accidents, hazards, health and safety issues, resident and staff feedback, audits and other. There are a low rate of incidents in the service. There is a 2020 audit schedule that has been implemented to April 2020. The monthly staff meetings have not been held at regular intervals. In the past year, meetings have been held in January, May, October 2019 and in January 2020 with a partial meeting held via zoom in July 2020.	Because of the irregularity of meetings, the quality improvement data has not been discussed with staff at regular intervals. The audit schedule has not been implemented since May 2020.	Discuss quality improvement data at monthly meetings as per agenda. Continue to audit as per schedule to improve service delivery. 180 days

Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	There is an incident and accident policy. This includes instructions on completing neurological observations for any resident who has a fall involving a head injury or for an unwitnessed fall. Four incident forms were reviewed for residents who had had an unwitnessed fall. Neurological observations had only been completed once, as opposed to ongoing, with the result documented in the resident record.	Following an unwitnessed fall, ongoing neurological observations had not been completed as required per policy.	Ensure ongoing neurological observations are taken as required following an unwitnessed fall. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	An annual training schedule is documented. Only two sessions were provided in 2019. In 2020, there has been training on Covid-19 in June 2020 and one session in January 2020.	The training schedule has not been implemented as planned.	Implement the training schedule as planned. 180 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Moderate	Individual, group activities and regular events were on the activities programme. There were some residents who participated in individual activities, for example walks outside the facility and shopping, and could attend to community activities independently. Other residents required assistance, support and guidance to attend to individual or group activities on the planner. However, those residents who required support and guidance did not have this provided.	There was no activities coordinator to manage the activities programme since April 2020 since the one who was previously appointed has resigned. Those residents who could not participate in individual activities were not receiving support and guidance to participate in activities of choice.	Ensure that planned activities for residents are provided/ facilitated to develop and maintain strengths and residents' interests. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.