

Riverleigh Care Limited - Riverleigh Residential Care

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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: Riverleigh Care Limited

Premises audited: Riverleigh Care Ltd

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical

Dates of audit: Start date: 13 January 2021 End date: 14 January 2021

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: 59

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

Riverleigh Care is privately owned. The service provides hospital services (hospital and medical); rest home and residential disability services – physical level care for up to 66 residents. On the day of audit there were 59 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Services Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The facility manager is a registered nurse with many years in health management. She has been in the position for five years. She is supported by a clinical coordinator and a team of registered nurses and caregivers.

The service has a documented quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided at Riverleigh.

This audit has identified five areas requiring improvement around: internal audits, timeframes for assessments, care plan interventions, activities and evaluations of care.

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 service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

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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There is a business and quality plan with goals for the service that have been regularly reviewed. Riverleigh has a documented, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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An admission package is available for prospective residents and their families prior to or on entry to the service. Registered nurses are responsible for each stage of service provision, including assessment, planning and reviewing residents' needs, outcomes and goals. Resident and/or family/whānau input is evident. Care plans viewed in resident records demonstrated service integration.

The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. Medication policies reflect legislative requirements and guidelines. Medication charts sighted had been reviewed at least three-monthly by the general practitioner.

A range of individual and group activities is available and coordinated by the diversional therapist.

All meals are prepared on site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service.

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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The building has a current building warrant of fitness that expires September 2021. The maintenance person undertakes preventative and reactive maintenance.

Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. Policies and procedures are in place for essential, emergency and security services.

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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There are policies and procedures on safe restraint use and enablers. There was one resident voluntarily using an enabler and two residents with a restraint. A registered nurse is the restraint coordinator. Resident files included assessments, consents and care plans appropriate to the identified risk and care needed for enablers and restraint. Evaluations and reviews assessing the continued need for restraint were documented. Staff receive training around restraint and challenging behaviours.

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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator/registered nurse is responsible for coordinating education and training for staff. The infection control coordinator has completed annual external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	11	0	4	1	0	0
Criteria	0	36	0	4	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal, email and written on the complaints form is maintained by the manager using an online complaints' register. There have been three complaints since the previous audit plus one staff complaint. All complaints/concerns have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint, to the satisfaction of the complainant and all complaints have been discussed in weekly head of department and monthly staff and RN meetings. The staff complaint was investigated through an HR process and resolved.</p> <p>Three hospital level (including one funded through the Long-Term Support Chronic Health Conditions [LTS-CHC] contract and one respite), three rest home level residents (including one younger person disabled) and family members advised that they are aware of the complaint's procedure.</p> <p>A complaint through the advocacy network via the Health and Disability Commissioner has been responded to by the service and is currently with the Health and Disability Commissioner.</p>
<p>Standard 1.1.9: Communication Service providers</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The facility manager confirmed family are kept informed. Relatives (three hospital and one rest home) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>surveys and open-door communication with management. Monthly resident meetings encourage open discussion around the services provided. Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status. Residents interviewed (three hospital and three rest home including a younger person) stated they were happy with the open communication.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as 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>Riverleigh Care is privately owned. The service provides; hospital (geriatric and medical) medical, rest home care and residential disability services – physical level care for up to 66 residents. All beds are dual-purpose. On the day of audit there were 59 residents; 22 rest home residents, including one respite, and one younger person funded through the younger person with a disability contract (YPD). There were also 37 hospital residents including three funded through the YPD contract, three respite, and one funded through the Long-Term Support Chronic Health Conditions (LTS-CHC) contract. All other residents were under the age-related residential care services agreement (ARCC).</p> <p>The facility is managed by an experienced and suitably qualified manager who is a registered nurse (RN) who has been in this position for five years. The manager is supported by a clinical coordinator (who was on leave at the time of audit). The clinical coordinator is responsible for oversight of the clinical service in the facility. The manager and owner are in regular contact. The manager reported that the owner is supportive.</p> <p>There is a documented strategic plan, and quality plan and goals have been reviewed regularly to measure achievements and quality improvements.</p> <p>The general manager maintains an annual practicing certificate and has maintained at least eight hours annually of professional development that is related to managing a rest home and hospital including attending DHB forums and steering groups.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>PA Low</p>	<p>Riverleigh has a documented quality and risk programme, purchased from a quality consultant. The new system allows all data to be entered online for monitoring and tracking. There is also a previous online quality system. The service is transitioning between the two. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (four caregivers, two registered nurses and one cook) confirmed they are made aware of any new/reviewed policies.</p> <p>The service has continued to implement regular meetings including: weekly heads of departments meetings</p>

<p>principles.</p>		<p>and monthly staff and RN meetings. Since the previous audit the service has implemented monthly clinical review meetings with the DHB clinical specialists (mental health for older persons and gerontology).</p> <p>Meeting minutes evidenced discussion around quality data including (but not limited to) complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. Trends are identified and analysed for areas of improvement. Meeting minutes document in-depth discussion and ad hoc training linked to audits, incidents, restraint and infection control each month. Individual resident needs are discussed at meetings where issues have been raised. Caregivers confirmed on interview they were kept informed on quality data including corrective actions and quality initiatives.</p> <p>Internal audits reviewed were not all completed as scheduled. Corrective action plans were completed for any corrective actions required for the audits undertaken. The manager signs off completed corrective actions. Internal audits are discussed along with corrective actions as needed during staff and RN meetings.</p> <p>The service has a health and safety coordinator who has completed health and safety training. The health and safety committee, as part of the staff meeting, review monthly accident/incident reports and review the hazard reports and register. Falls prevention strategies are in place that include the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls. Health and safety information is displayed on the staff noticeboard.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>As part of risk management and the health and safety framework, there is an accident/incident policy. The service collects incident and accident data monthly and provides reports to all facility meetings. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted.</p> <p>Ten incident forms were reviewed from November 2020. All incident forms identified timely RN assessment of the resident and corrective actions or recommendations that had been completed and signed off by the manager. Neurological observations have been completed for unwitnessed falls and any known head injury as well as follow-up to ensure safety. The caregivers interviewed could discuss the incident reporting process, they also described the discussion of incidents at monthly meetings.</p> <p>The manager could describe situations that would require reporting to relevant authorities. No reporting has been required since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. The register of RN practising certificates and allied health professionals is current. Five staff files were reviewed: (two RNs, one cook and two caregivers). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Care staff interviewed were able to describe the orientation process and</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>believed new staff were adequately orientated to the service.</p> <p>Registered nurses have access to external training that includes clinical education relevant to medical conditions as well as monthly case reviews (the clinical review meeting). The in-service education delivered by internal and external educators was interrupted during Covid-19 lockdown, however the service has caught up recently, ensuing all education for 2020 has been provided. During Covid-19 lockdown the service provided daily updates and training to ensure safe infection control including PPE, donning and doffing, and Covid-19 information.</p> <p>Ad hoc training has been delivered though staff meetings related to new policies and issues raised each month though audits and incidents. Nine of ten RNs including the clinical coordinator are interRAI competent. Staff complete competencies relevant to their roles.</p> <p>Training has included reference to younger people and has included privacy abuse and neglect, as well as the monthly case reviews with the DHB addressing issues raised and specific care needs.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented policy that determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The manager (RN) and clinical coordinator (RN) are on duty during the day Monday to Friday. Both share the on-call requirement for clinical and non-clinical concerns. There are two RNs on the AM and the PM shift (one long shift and one short shift) and one RN at night.</p> <p>There are four caregivers on the AM and four on the PM shift (two long and two short shifts) and two caregivers on the night shift. Caregivers interviewed were happy with staffing levels.</p> <p>Residents and relatives stated there are adequate staff on duty at all times. Staff stated they feel supported by the clinical coordinator and manager who respond quickly to afterhours calls.</p> <p>There are dedicated laundry and cleaning staff.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	<p>FA</p>	<p>Policies and procedures are in place for safe medicine management that meet legislative requirements and guidelines. Registered nurses and, at times, a medication competent carer administer medications. They are assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart. Medications are stored safely. The medication fridge and room are maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There was one resident self-administering medication on the day of audit. The resident had a locked drawer in their room and assessments and three-monthly reviews documented.</p> <p>Ten electronic medication charts reviewed met legislative requirements. Medications had been signed as</p>

guidelines.		administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication round. There was evidence of regular audits undertaken to ensure that registered nurses document the effectiveness of 'as needed' medication.
<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>	FA	<p>All meals are prepared and cooked on site at Riverleigh Care. The Food Control Plan expires October 2021. The chef is responsible for the operations of food services. The kitchen team includes a relief cook and four kitchenhands. All kitchen staff have completed food safety training.</p> <p>There is a four weekly rotating summer and winter menu that has been approved by a dietitian. A food services policies and procedures manual is in place. All food is served directly from the kitchen to residents in the dining room or to their rooms as required. A tray service is available if required by residents.</p> <p>All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The cook maintains a folder of resident's dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. The chef caters for dietary preferences including catering for a resident who likes curries.</p> <p>The chef attends resident meetings, and at the meetings residents express their feedback on meals and food services. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered.</p> <p>All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Daily hot food temperatures are taken and recorded for each meal. Holding temperatures are taken. Fridge and freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date labelled and stored correctly. The kitchen has a dishwashing area, preparation, cooking, baking and storage areas.</p> <p>The chemicals are stored safely. Safety data sheets are available, and training provided as required. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate</p>	PA Moderate	<p>All five resident files documented a care plan; however, not all care interventions were fully documented and not all care interventions such as pain management were evidenced to be implemented. If a resident's condition alters, a registered nurse initiates a review and if required contacts a general practitioner or nurse specialist. Files reviewed demonstrated that families are notified of any changes to their relative's health.</p>

<p>services in order to meet their assessed needs and desired outcomes.</p>		<p>This was confirmed in interview.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for residents with wounds.</p> <p>Six wounds were documented on the wound log. The wound included three pressure injuries; two facility acquired (both stage two) and one non-facility acquired (stage one). Other wounds included two ulcers and one skin tear.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. Monitoring forms are documented and completed as needed.</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>	<p>PA Low</p>	<p>The service employs an activities coordinator and activities officer who provides activities Monday to Friday. The activities coordinator was away on the days of audit but has been in the role since the previous audit. During weekends caregivers provide some activities and once a month, a non-denominational church service is held on a Sunday.</p> <p>The activities programme includes news and views, skittles, indoor walking, board games, cards, puzzles, housie and happy hour. Entertainers are invited to the facility twice a month. A pre-school regularly visits. The activity plan includes a visit by the Mr Whippy van, and there are plans to involve canine friends. There are budgies and a rabbit at the facility. Regular outings into the community occur, a taxi van is used, and the driver has a current first aid certificate.</p> <p>One-on-one activities occur for residents who choose not to be involved in group activities. Themes and events are celebrated. The needs of younger residents were not well addressed.</p> <p>An activities assessment is completed on admission. Individual activity plans were seen in long-term resident files. The service receives feedback and suggestions for the programme through monthly resident meetings and direct feedback from residents and families.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	<p>PA Low</p>	<p>Initial care plans for long-term residents were evaluated by a registered nurse within three weeks of admission and long-term care plans developed. Not all the files reviewed evidenced that long-term care plans had a documented evaluation by a registered nurse six-monthly. However, care plans have been updated six-monthly. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p>

manner.		
<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	<p>The building has a current building warrant of fitness that expires September 2021. The maintenance person undertakes preventative and reactive maintenance. The annual maintenance plan includes monthly checks for hot water temperatures, call bells, resident equipment and safety checks. Daily maintenance requests are addressed. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Contractors are available after hours as required.</p> <p>The service is on two levels. There are 33 resident rooms upstairs and 25 rooms downstairs. There are eight double rooms in all over the two floors. Privacy curtains are in place for all double rooms. There is a lift between floors. The lift has a lift inspection undertaken monthly. The facility has wide corridors with space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade are provided.</p> <p>The registered nurses stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the staff and RN meetings. Trends are identified, and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule (link 1.2.3.7). There is close liaison with the GP who advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks.</p> <p>The service closed during the Covid-19 lockdown. The service provided education for staff around PPE, infection control and handwashing. Meeting minutes document reminders and updates for staff. There are outbreak boxes and posters in preparation for any further pandemic related issues.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit, there was one resident with an enabler and two residents with a restraint. All enablers and the restraint were bed rails. Two resident files reviewed; one for restraint and one for enabler use, both documented an assessment, consent and regular reviews. Restraint and challenging behaviour education are included in the training programme.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	There is a well-documented quality and risk programme. The programme includes online processes to track and monitor quality data, this includes an internal audit schedule. However, some of the quality processes are still using an older process and some the new quality system. This has resulted in not all internal audits being completed.	Not all internal audits have been undertaken as per schedule and/or have not been fully completed.	<p>Ensure that all internal audits are undertaken as per schedule.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the</p>	PA Low	All resident files reviewed included an up-to-date care plan. However, the assessment process and timeframes were not always completed according to policy.	<p>(i) Timeframes for routine interRAI assessments were not within timeframes for one rest home and one hospital level resident under the ARRC contract.</p> <p>(ii) One YPD (rest home level)</p>	<p>(i) Ensure that interRAI assessments are documented within timeframes.</p> <p>(ii) Ensure that there is a</p>

needs of the consumer.			and one LTS-CHC (hospital level) had no formal assessments on their file.	documented assessment process for those residents who are not assessed using the interRAI system. 90 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>All resident files included a care plan. However, not all care plan interventions were fully documented and not all care interventions were evidenced to be provided.</p>	<p>(i) Recognition and treatment of seizures was not documented in one rest home and one hospital level residents' file.</p> <p>(ii) Management and interventions for pain control was not documented or implemented in one rest home level resident's file.</p> <p>(iii) The wound care specialist has not documented the wound review or advice given to staff.</p> <p>(iv) A hospital level long-term respite resident did not have; monthly blood sugar levels and catheter bag care, in their care plan.</p>	<p>(i) Ensure that the recognition and treatment of seizures is documented in residents' care plans for residents with known seizure activity.</p> <p>(ii) Ensure that the management and interventions for pain control are documented and implemented for residents with known pain.</p> <p>(iii) Ensure that the wound care specialist documents the wound review and advice given to staff.</p> <p>(iv) Ensure that all interventions are</p>

				documented in the resident's care plans including: blood sugar levels and catheter bag care. 60 days
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	Activities are planned monthly and include a wide range of activities for the residents. Each resident also has an individual activity plan documented, following an individual assessment. The individual plans did not reflect the interests of the two younger person files reviewed and the overall facility activity plan did not provide for the younger age group.	The individual activity plans for two younger residents did not reflect the needs of the age group or their assessment. The overall activity plan for the service did not provide for the activity need for the younger resident group.	Ensure that there are activities for the younger residents' which reflect their needs and community links. 90 days
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	Each resident file reviewed documented a care plan, there was evidence that care plans had been updated with changes and care plans were updated six-monthly. However, a formal evaluation of care was not documented for the four long-term resident files reviewed.	Two hospital level and two rest home level resident files did not have a formal evaluation of care documented.	Ensure that six monthly evaluations of care are documented and include progress towards stated goals. 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.