

Experion Care NZ Limited - Bardowie Retirement Complex

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 Q-Audit 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:	Experion Care NZ Limited
Premises audited:	Bardowie Retirement Complex
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 July 2021 End date: 22 July 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:	18

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

Bardowie Retirement Complex currently operates as a stage two (2) rest home and is situated on the main arterial highway leading into the city of Napier. The service is one of six facilities owned by Experion Care NZ Limited in Hawkes Bay and provides rest home care for up to 19 residents with the other room being used as the nurse manager's office. The service is operated by Experion Care NZ Limited and co-managed by two nurse managers. There were 18 residents at the time of the audit. Residents and families spoke positively about the care provided.

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

There were four areas identified requiring improvement during the audit and these relate to, human resources, service delivery, medication management systems, and a safe and appropriate environment.

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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Open communication between staff, residents, and families is promoted. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

The complaints process meets the requirements of consumer rights legislation. A complaints register has been maintained.

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 strategic and business plan, quality risk management plans include the scope, direction, goals, values, and mission statement of the organisation and this was for 2018-2022 period. Monitoring of the services provided to the management is regular and effective. An experienced and suitably qualified person manages the service.

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

The appointment, orientation, and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance reviews. Staffing levels and skill mix meet the changing needs of residents.

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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All stages of service provision were completed in a timely and competent manner. The Nurse Manager (NM) is responsible for completing nursing assessments and care plans with input from other healthcare providers as required. Planned activities are appropriate to the residents' needs and abilities. InterRAI assessments were completed within required timeframes and the clinical assessment protocols (CAPs) were integrated with the care plan. The meal service meets the individual food, fluids, and nutritional needs of the residents. Residents with special dietary needs are catered for.

A safe medication management system is in place and meets legislative guidelines and policy requirements. The service uses an electronic medication system. All medication records had been reviewed within the past three months by the general practitioner.

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.		Some standards applicable to this service partially attained and of low risk.
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There is a current building warrant of fitness. Trial evacuations are conducted as required.

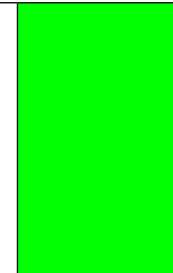
Restraint minimisation and safe practice

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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no restraints are in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. The use of enablers is voluntary and as the least restrictive option. Staff training on restraints/enablers and challenging behaviour was conducted.

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 is developed in consultation with the relevant key stakeholders. The environment is managed in a way that minimises the risk of infection to residents, staff, and visitors. The infection control coordinator (ICC) is responsible for monitoring infections, surveillance of data, trends and implementing relevant strategies. There was no infection outbreak 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	3	1	0	0
Criteria	0	35	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 service has a complaints management policy and procedures in place that align with the Code. The service's complaint register is detailed regarding dates, timeframes, complaints, and actions taken. All complaints sighted in the register had been resolved. There had been zero complaints in 2020 and one (1) complaint in 2021. This complaint required the involvement of the health and disability commission (HDC) and was resolved amicably.</p> <p>Complaint's information is used to improve services as appropriate. Quality improvements or trends identified are reported to the staff. Residents and families are advised of the complaints process on entry to the service. This includes written information about making complaints. Family/whanau interviewed describe a process of making complaints that includes being able to raise these at residents' meetings, putting a complaint (which can be anonymous) in the suggestion box, or directly approaching staff or the facility manager.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures. Personal, health, and medical information is collected to facilitate the effective care of residents.</p> <p>There were no residents who required the services of an interpreter however staff know how to access interpreter</p>

<p>provide an environment conducive to effective communication.</p>		<p>services if required. Staff can provide interpretation as and when needed; the use of family members and communication cards when required is encouraged.</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 2018-2022 strategic and business plan documents describe annual and long-term objectives and the associated operational plans. The strategic and business plan sighted included the scope, direction, goals, values, and mission statement of the organisation. The Co-Nurse Manager reported that the service was certified for 20 beds. Monthly reports to the executive director (owner) showed adequate information to monitor performance is reported including potential risks, contracts, human resource and staffing, growth and development, maintenance, quality management, and financial performance.</p> <p>The service is co-managed by two part-time nurse managers, ensuring both onsite and after-hours registered nurse coverage. The nurse manager is supported by the executive director (owner). The management team meets on regular basis. All members of the management team are suitably qualified and maintain professional qualifications in management, finance, and clinical skills. Both nurse managers are registered nurses with current practising certificates and attend regular conferences conducted by the local district health board. The service is managed by nurse managers who have over 15 years' experience and knowledge in the health sector. Responsibilities and accountabilities are defined in a job description and individual employment agreement.</p> <p>The service holds contracts with the district health board (DHB), ministry of health (MOH) for the provision of rest home care, mental health, respite services, and long-term support chronic health conditions (LTS-CHC). There were 18 residents receiving services on the day of the audit. At the time of the audit, there were 16 residents assessed as requiring rest home level of care and two (2) LTS-CHC.</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>FA</p>	<p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit programme, regular family/resident satisfaction surveys, monitoring of outcomes, clinical incidents, and accidents including infections surveillance.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed to the executive director (owner) management team and staff meetings. The nurse managers' report monthly to the executive director (owner). A quality and risk report is compiled and evidence of previous reports was sampled. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed yearly and evidence of this was sighted.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI long Term Care Facility (LTCF) assessment tool process. Policies are based on best practices and are</p>

<p>principles.</p>		<p>current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. These are managed by an external consultant who keeps the service updated on any recent changes. In the interview conducted. Staff confirmed that they have access to policies and procedures if required.</p> <p>The nurse managers described the process for the identification, monitoring, review, and reporting of risks and the development of mitigation strategies. The nurse managers are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near-miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up promptly. Neurological observations are completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed, and reported to the management, respectively. There is an open disclosure policy in place. Any communication with a family and general practitioner (GP) following adverse events and if there is any change in the resident's condition, is recorded in residents' records. Family/whānau and the GP interviewed confirmed they are notified in a timely manner.</p> <p>The nurse managers described essential notification reporting requirements, including for pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks, and missing persons. They advised there have been no notifications of significant events made to the MOH since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the</p>	<p>PA Low</p>	<p>Human resources management policies and processes are based on good employment practices and relevant legislation. The recruitment process includes reference checks, police vetting, and validation of qualifications and practicing certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them adequately for their role.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff has either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff training is being provided. There were six (6) Health care assistants (HCA's) with level three and three (3) with career force training. Staff reported that they were currently receiving ongoing training to meet the needs of residents requiring rest home level of care. The other co-</p>

requirements of legislation.		nurse manager is competent and maintains annual competency requirements to undertake interRAI assessments. An improvement relating to completing staff appraisals annually is required.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe delivery, 24 hours a day, seven days a week. The service adjusts staffing levels to meet the changing needs of residents. An after-hours on-call roster is in place, with staff reporting that good access to advice is available when required. Care staff reported there was adequate staff available to complete the work allocated to them. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All shifts have a staff member on duty with a current first aid certificate and the nurse managers cover during the day. The service has adequate staff to cover any increased needs.
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.	PA Moderate	The medication policies and procedures are aligned with legislation, guidelines, and best practice and are available to staff. The service uses an electronic medication prescribing and administration platform. All medication records contained a photograph of the resident with the allergy status completed. As required' medications had indications and maximum doses and short courses medications had a start and finish date. There are no controlled drugs kept on the premises. All medication records had been reviewed within the past three months by the general practitioner. Medications are dispensed and delivered from a local pharmacy. All medications are checked by the registered nurse on arrival. Caregivers administer medication under the direction and delegation of the registered nurse. A medication round was observed, the principles of safe medication administration were followed. No residents were self-administering medication during the audit. A self-administration procedure is available, as is a self-administration competency test. Self-administration of medication is generally used for topical medications only. Medication training to the caregivers is provided annually by the NM/RN. Caregivers interviewed were aware of their scope of practice and stated they contacted the NM/RN on-call before administration of 'as required' medications. An improvement is required to ensure open bottles of eye drops in use are dated and medication competencies for staff administering medicines are current.
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	Meal services are prepared on-site and served in dining rooms. The four weekly seasonal rotating menus have been reviewed by the registered dietitian and are valid. Diets are modified as required and the main cook interviewed confirmed awareness of dietary needs required by the residents. Alternative meal options are offered as

<p>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>required. The residents' weights are monitored monthly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night on a 24-hour period. The family/whanau interviewed acknowledged satisfaction with the food service. The kitchen was audited and registered under the food control plan; the current food plan certificate was sighted. Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges, and freezers temperatures are maintained. Regular cleaning is conducted.</p>
<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>	<p>FA</p>	<p>The documented interventions in the long-term care plans address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders are carried out as confirmed in the medical notes. Progress notes are completed on every shift. The service has in place process of weekly handover review of all residents completed by the NM, evidence sighted . observations are completed and are up to date. Clinical supplies are adequate, suited to the levels of care provided, and in accordance with the residents' needs, the staff confirmed they have access to the supplies and products they 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>FA</p>	<p>Activities are planned and implemented by the activity's coordinator. Activities are resident focussed and appropriate for people at the rest home level. A weekly planner is posted on the notice boards that are accessible to residents in all wings of the facility. The activities provided take into consideration residents' interests and abilities. There is a wide range of activities offered: including bingo; quiz; music sessions; walking groups; van outings art, craft, and various events celebrations. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. There is a monthly budget set for activities, and this is utilised when needed. There is community involvement with external entertainers invited, and community groups. Attendance lists are completed daily, and documentation is maintained. Comprehensive activities assessment and activities plans were sighted in sample files. Evaluation of the individual activity plans is completed every six months, or when there is a significant change. Monthly residents' meetings are conducted, and outcomes are implemented and communicated to family and residents. Residents and family members interviewed reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit, and special event celebrations.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>PA Low</p>	<p>Residents' care plans are personalised and reflect interRAI assessments and re-assessments. Activity plans are evaluated at least every six months and updated when there are any changes. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short-term care plans are</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>developed when needed and signed and closed out when the short-term problem has been resolved. Initial care plans for long-term residents were evaluated by the registered nurses within three weeks of admission. Written evaluations reviewed, identified if the resident goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented in the resident hard copy file. Improvement needed to ensure there is family involvement in the resident Care plan and related reviews.</p>
<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>	<p>FA</p>	<p>There have been no changes to the facility since the last audit. The current building warrant of fitness was sighted, and it expires 1 June 2022.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>Trial evacuations were not consistently completed every six months as required and the last fire drill was conducted in April 2020. Records of staff attendance are maintained. There is an approved emergency evacuation plan. An improvement is required to ensure trial evacuations are conducted as per policy and legislation requirements.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p>	<p>FA</p>	<p>The surveillance programme is defined and appropriate to the size and scope of the service. All infections are recorded in the residents' files using the nosocomial infection data collection form. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and management meetings. Evidence of completed infection control audits was sighted.</p> <p>Staff interviewed confirmed that they are informed of infection rates as they occur. The GP is informed within the required time frames when a resident has an infection and appropriate antibiotics are prescribed for all diagnosed</p>

<p>and methods that have been specified in the infection control programme.</p>		<p>infections. There has been no outbreak since the last audit. A pandemic plan is in place and adequate personal protective equipment was sighted. Staff, residents, and families are updated on regular Covid-19 latest information.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Bardowie Rest Home has restraint minimisation policies and procedures that document the risk assessment process, approvals, monitoring and communicate its commitment to restraint minimisation. The definition of restraint and enabler is clearly stated in the organisation's restraint policy. A restraint register was sighted. On the day of the audit, no residents were using restraints and no residents were using enablers. Processes are in place if either is in use. The organisation's policy states that approved methods of restraint and enablers are bed rails, lap belts, and harnesses. Interviewed staff demonstrated knowledge of the difference between an enabler and a restraint. The service advocates for the least restrictive method of restraint to be used, and the use of enablers be voluntary and the least restrictive option. Staff training on restraint/enabler and challenging behaviour was conducted.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>The policy requires that staff appraisals are completed annually. Staff performance is monitored, and four (4) out of seven (7) annual performance appraisals were overdue for review.</p>	<p>Four (4) out of seven (7) staff appraisals were not completed according to policy requirements.</p>	<p>Ensure annual performance appraisals are completed as per policy requirements.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing,</p>	PA Low	<p>A medication round was observed, the principles of safe medication administration were followed.</p> <p>Eye drops in use kept in medication trolley checked, Six of the eye drops in use have no opening date written on the eye drops bottle.</p>	<p>Six of the eye drops in use have no opening dates written</p>	<p>Ensure all eye drops in use have opening dates written on the eye</p>

dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.			on the eye drops bottle.	drops bottle. 90 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	The medication policies and procedures are aligned with legislation, guidelines, and best practice and are available to staff. All medications are checked by the registered nurse on arrival. Caregivers administer medication under the direction and delegation of the registered nurse. No documented evidence of staff medication competencies was provided by staff on audit day. Medication competencies were not completed as per policy requirements.	Medication competencies were not completed as per policy requirements.	Provide evidence of completed medication competencies. 90 days
Criterion 1.3.8.2 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.	PA Low	Residents' care plans are personalised and reflect InterRAI assessments and re-assessments. Ongoing nursing evaluations occur as indicated and are documented in the resident hard copy file. The facility using a care plan form to be signed by the family when the care plan is approved/ reviewed, in addition to nursing staff to confirm resident /family involvement by completing the section in the care plan. There was no family signature on the care plan designated form, and nursing staff did not complete the resident/family involvement section on the care plan. There were no evidence residents/family involved in the care plan and related review.	There was no evidence residents/ family involved in the care plan and related reviews.	Provide evidence of resident /family involved in the care plan and related reviews. 90 days
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Low	The policy and legislation require that trial evacuations are conducted six-monthly. The last fire drill was conducted in April 2020.	Fire drills were not conducted as per policy requirements.	Ensure fire drills are completed within the required timeframes. 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.