

Oceania Care Company Limited - Ohinemuri Care Centre

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Oceania Care Company Limited
Premises audited:	Ohinemuri Rest Home and Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 4 May 2017 End date: 5 May 2017
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:	63

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

General overview of the audit

Ohinemuri Rest Home and Village provides rest home, hospital and dementia level of care for up to 68 residents. On the day of audit there were 63 residents residing at the facility.

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

There were two areas identified as requiring improvement at the last certification audit. One improvement relating to residents' agreements has been met and the second area requiring improvement relating to activities remains open.

There are three areas identified as requiring improvement at this surveillance audit relating to the complaints management system, staff orientation and activities.

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

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are accessible at the facility. This information is also brought to the attention of residents and their families on admission to the facility. Residents confirmed their rights are being met, staff are respectful of their needs and communication is appropriate.

The service has a documented complaints management system and a complaints register is 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.
---	--	---

Oceania Healthcare Limited is the governing body and is responsible for the services provided at Ohinemuri Rest Home and Village. The organisation has documented its scope, direction, goals, values, and mission statement and these are communicated to all concerned.

The quality and risk management system and processes support safe service delivery. Quality and risk management activities and results are shared among staff, residents and family, as appropriate. Systems are in place for monitoring the services provided. The quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status and clinical indicator reports.

The service is overseen by the regional clinical and quality manager who is supported in their role by a clinical manager. The clinical manager is responsible for the oversight of the clinical services in the facility.

There are human resource policies implemented around recruitment, selection and staff training and development. An in-service education programme is provided for staff.

The service maintains their documented staffing levels and skill mix to ensure contractual requirements are met. Staff are allocated to support residents as per their individual needs.

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 low risk.
--	--	---

Registered nurses assess residents on admission. Residents' needs assessments are completed within the required timeframes.

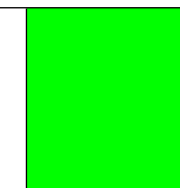
Person centred care plans are individualised and based on a comprehensive and integrated range of clinical information. Short-term care plans are in place to manage short-term problems. Residents' records reviewed demonstrated their needs, goals and outcomes are identified and reviewed at regular intervals. Interviews confirmed residents and their families are informed and involved in care planning and evaluation of care. Handovers guide continuity of care.

The activity programme is managed by the activities coordinators and reviewed annually by a diversional therapist. The programme provides most residents with a variety of individual and group activities, including additional activities for younger people with disabilities. The service uses its facility bus for outings in the community.

Medicines management occurs according to policies and procedure, in alignment with legislative requirements and consistently implemented using an electronic system. Medications are administered by registered nurses and senior healthcare assistants. Medicines management competencies for staff who administer medicines were current.

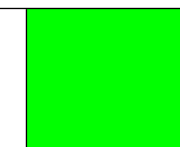
The facilities food service meets the nutritional and other specific needs of the residents. Staff have food safety qualifications. The kitchen was clean and meets food safety standards. Residents confirmed satisfaction with meals.

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 building warrant of fitness. There have been no building modifications since the last audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	---	--

The organisation implemented policies and procedures that support the minimisation of restraint. There were no enablers in use and one restraint was in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. Enabler use is voluntary. Staff interviews confirmed understanding of the restraint and enabler processes.

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.
---	--	--

Infection surveillance is undertaken, analysed, trended and benchmarked. Results are reported to the Oceania Healthcare Limited support office. Surveillance records showed evidence of follow-up of infections, when required. Staff demonstrated current knowledge and practice in relation to the implementation of infection prevention and control. The infection prevention and control programme is reviewed annually.

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	0	0	0
Criteria	0	38	0	3	0	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>	PA Low	<p>The complaints management policy meets Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The complaint forms and the complaint process are accessible to staff, residents and family. Residents and family are advised of the complaints process on admission. Residents and family interviewed demonstrated an understanding and awareness of how to make a complaint. Staff confirmed that they understand and implement the complaints process when required.</p> <p>The regional clinical and quality manager is responsible for the management of complaints at the facility. The complaint register for 2017 does not record any complaints. The 2016 register and complaints were reviewed and identify that the complaints processes are not consistently followed.</p> <p>There have been no complaints submitted to external agencies.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Review of residents' clinical files evidenced timely and open communication with residents and family members. Communication with family members is recorded in the progress notes and on the family communication sheets. Staff and management interviews confirmed family members are kept informed about any change in a resident's condition and if any adverse event occurs. This was evidenced in clinical files reviewed. The family interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident.</p> <p>Policies and procedures are in place for accessing interpreter services. Staff and management interviews</p>

<p>conducive to effective communication.</p>		<p>confirmed there were no residents requiring interpreter services on audit days. Interpreter services are accessible, when required.</p> <p>The resident information pack includes all relevant information including information for people with dementia.</p> <p>Review of residents' admission agreements confirmed the previous area requiring improvement from the last certification audit has been met.</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>Services are planned to meet the needs of the residents at rest home, hospital and dementia level of care. The service has a documented mission statement, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training.</p> <p>Ohinemuri Rest Home and Village is part of Oceania Healthcare Limited with the executive management team providing support to the service. The regional clinical and quality manager (CQM) has been in their role since March 2017, during the last certification audit the CQM was the business and care manager (BCM). The CQM will continue to support the facility in a combined role until a new BCM commences employment. Interviews with the CQM confirmed there has been recent appointment to the role of the BCM and this appointment will commence on 15 May 2017.</p> <p>The clinical care service is overseen by the clinical manager (CM) who is a registered nurse (RN) and has been in this position for approximately 11 months. Both the CQM and the CM attend study days and additional training and education specific to management, exceeding eight hours annually. HealthCERT have been informed of the new appointments at the facility.</p> <p>The facility can provide care for up to 68 residents with 63 beds occupied on audit. This included 33 residents requiring rest home level care, 19 residents requiring hospital level care and 11 residents in the dementia unit. Three residents were identified as being under the young people with disability contract, all at rest home level of care. The contract with the district health board (DHB) includes residential care rest home, hospital and dementia levels of care, respite care and young persons with disability contracts.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and</p>	<p>FA</p>	<p>The service uses Oceania Healthcare Limited's quality and risk management framework. The framework is documented to guide practice and to minimise risks to residents, staff and visitors. The key components of service delivery are linked to the quality management system. Quality and risk issues are discussed at facility's meetings. The monthly facility business status report provides the executive management team with progress against identified indicators. Management and staff confirmed quality activities are discussed at regular meetings and they are kept informed of quality improvements.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies and</p>

<p>risk management system that reflects continuous quality improvement principles.</p>		<p>procedures are current, reflect best practice, meet legislative requirements and are reviewed regularly as defined by policy. When policies are updated, changed or new policies introduced, these are distributed to staff to read and sign to confirm they have read and understood the new policy. The document control system ensures that obsolete documents are removed from use. Staff stated they are informed of new and revised policies.</p> <p>The service has a comprehensive internal auditing programme that covers all aspects of service delivery. Regular audits are undertaken and corrective action planning put in place to manage any shortfalls identified. The 2017 resident satisfaction survey shows satisfaction with services provided and this was confirmed by resident interviews.</p> <p>The service has a documented health and safety programme, which includes managing hazards, reporting and investigating accidents, planning for emergencies, and health and safety education to ensure staff, visitors and contractors meet the standards. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated.</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>Management understand their obligations in relation to essential notification reporting and know which regulatory bodies must be notified. Excluding new management notification, there have been no other events that have required essential notification to the appropriate authorities.</p> <p>The incident and accident reporting processes are documented and any corrective actions to be taken are shown on the forms used by the service. Management confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated. Corrective action plans to address areas requiring improvement were documented on accident/incident forms sighted.</p> <p>Staff stated they report and record all incidents and accidents, and this information is shared at all levels of the organisation, including any follow up actions required being reviewed at facility meetings. Residents' files evidenced staff are documenting adverse, unplanned or untoward events on accident/incident forms. The registered nurses undertake assessments of residents following an accident/incident and this is recorded on an accident/incident form and in the resident's clinical file.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	<p>PA Low</p>	<p>Staff that require professional qualifications have them validated as part of the employment process. Annual practising certificates were signed for all staff and contractors who require them. Staff undertake training and education related to their appointed roles. The CM and two RNs have completed the required interRAI training. One RN is in training and another RN is scheduled for training.</p> <p>Written policies and procedures in relation to human resource management are documented. Management stated staff complete an orientation programme that covers the essential components of health and safety and</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>service delivery, with specific competencies for their roles. However, completed orientation booklets were not sighted in all staff files reviewed. Newly appointed staff are police vetted upon employment, referees are checked and job descriptions clearly describe staff responsibilities and best practice standards, as sighted in staff files reviewed. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.</p> <p>The in-service education programme and the core study days were reviewed and evidence staff education is provided to all staff. The core study days are provided for RNs, health care assistants and non-clinical staff. The core study days provide mandatory education and training in the required areas relevant to the levels of staff responsibilities and authority. The staff working in the dementia unit have completed specific training relating to dementia. There are new staff working in the dementia unit (employed in last two to five months) who are required to commence or complete dementia education and training. The clinical manager is aware of this requirement. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided. Competency assessment questionnaires are current for medication management and restraint.</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>Oceania Healthcare Limited (Oceania) policies identify staffing levels and skill mix to meet residents' needs and to comply with the DHB's contractual requirements and safe staffing guidelines. Documentation reviewed confirmed adequate numbers of suitably qualified staff are on duty to provide safe and quality care. There is a RN on duty every shift and the CM and the CQM are on call after hours and weekends. The on-call arrangements are known to staff.</p> <p>Residents interviewed stated their needs are met in a timely manner. Staff confirmed there are adequate staff on each shift and they have time to complete all tasks to meet residents' needs. Staffing levels and skill mix are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents.</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 guidelines.</p>	<p>FA</p>	<p>The medicine management system is documented and implemented and complies with legislation, protocols and guidelines. The service uses pharmacy pre-packaged medicine that is checked by the RN on delivery. A computer based medication system is used. Weekly checks and six-monthly stocktakes are conducted and confirmed that stock levels were correct. The medication refrigerator temperatures are monitored. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are stored appropriately.</p> <p>The staff administering medication complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled.</p> <p>There were two residents who self-administered medications on audit days. All checks and reviews are completed for these residents to ensure they are competent to self-administer medicines. Policies and</p>

		procedures are in place to ensure safe storage and alignment with policy in relation to self-administration of medications.
<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>Meals are prepared on site and served in three different dining rooms. The seasonal menu has been reviewed by a dietitian. Kitchen staff have current food management certificates. Diets are modified as required and the cook confirmed awareness of the dietary needs of residents.</p> <p>Residents' dietary profiles are developed on admission and identify the residents' dietary requirements and preferences. The dietary profiles are communicated to kitchen staff on a resident's admission to the facility, when a resident's dietary needs change and when dietary profiles are reviewed six monthly. Supplements are provided to residents with identified weight loss problems.</p> <p>Food containers are labelled and dated. Records of temperature monitoring of food, refrigerators and freezers are maintained. Regular cleaning is undertaken. Food services comply with current legislation and guidelines. Decanted food had records of use by dates recorded. Interviews with residents and their families confirmed satisfaction with the food service.</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>	FA	<p>The residents' care plans are completed by the RN and based on assessed needs, desired outcomes and goals of the residents. Care planning includes specific interventions for both long-term and the short-term problems.</p> <p>The GP documentation and records are current. Interviews with residents and families confirmed that care and treatment meets residents' needs. Staff interviews confirmed they are familiar with the needs of the residents. Family communication is recorded in the residents' files. The nursing progress notes and observation charts are maintained.</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>	PA Low	<p>The residents' activities programme is developed by the activities coordinators and annually reviewed by the diversional therapist. The activities programme was implemented.</p> <p>The residents' activities assessments are completed within the three weeks of the residents' admission to the facility. Information on residents' interests are gathered during an interview with the resident and their family. The activity care plan is part of the long-term care plan and reflects the residents' preferred activities, however, not all resident activity plans identified current activities and is a requirement for improvement (refer to 1.3.7.1).</p> <p>Residents in dementia care have additional activities to help manage behaviour 24 hours day. The residents in the dementia unit have challenging behaviour management plans on file.</p>

		<p>The service had two residents under the age of 65 with specific care plans including additional social activities to meet their specific needs.</p> <p>There was evidence the activities staff are part of the interRAI evaluation process. The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging in a variety of activities and outings. Resident meetings are conducted bimonthly.</p> <p>The previous shortfall relating to activity plans not including current interests or abilities remains open.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term and the short-term care plans are evaluated in a timely manner. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Residents' responses to the treatment regime are documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved.</p> <p>The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved. Short-term care plans are developed when needed and record goals and the required interventions for the identified short-term problems.</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>	FA	<p>The building warrant of fitness is current. The CM stated there have been no alteration to the buildings since last certification audit.</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>The surveillance policy identifies the requirements around the surveillance of infections. The infection logs are maintained and collated monthly by the CM. One of the RNs is the infection prevention and control nurse.</p> <p>Collated data are communicated as clinical indicators to the Oceania support office and to management and staff. Residents' files evidenced that those residents diagnosed with an infection had short-term care plans in place. The GP interview confirmed infections are reported in a timely manner.</p> <p>In interviews, staff reported they are made aware of any infections through feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was confirmed during attendance at the handover and review of the residents' files. The CM confirmed that there had been no outbreaks of infection at the facility since the last audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The Oceania restraint minimisation and safe practice handbook and policies comply with legislative requirements. The restraint coordinator is the CM. A signed position description was sighted. There was one resident using restraint and no enablers were being used during the on-site audit days. The restraint register is maintained and current. Required documentation relating to restraint is recorded. Staff receive restraint education via the Oceania study days and RN study days.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>The 2016 complaints register records four complaints that were reviewed to ensure the process followed Right 10 of the Code. One of the four complaints did not evidence that a written acknowledgement of the complaint was sent to the complainant within five working days of receipt of the complaint.</p> <p>The complaints investigation forms record the investigations have occurred, however, the details of the investigations are not recorded.</p> <p>There is no documented evidence from the complainants that the complaints have been resolved to their satisfaction.</p>	The complaint process does not consistently follow Right 10 of the Code.	<p>Ensure all steps relating to a complaint comply with the Code.</p> <p>180 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers</p>	PA Low	<p>Oceania policies and procedures around staff orientation are documented. The orientation programme covers the essential components of the services</p>	Staff orientation records are not	Provide evidence of

receive an orientation/induction programme that covers the essential components of the service provided.		provided. Review of nine staff files evidenced two of the nine staff files did not contain evidence of orientation of these staff members. Additional four files of new staff were sampled in respect of orientation being completed and evidenced two of the four additional files did not contain records of completed orientation.	consistently completed or located on staff files.	completed orientation records for all new staff employed. 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 Low	Resident records reviewed evidenced activity assessments on admission to the service. All activity records reviewed showed timely review, however, not all resident records identified current activities or those activities that the resident could participate in at the time of the audit. Residents interviewed were satisfied with the activities programme.	Two of six resident records reviewed did not include current activities or activities the resident could participate in.	All resident assessments to include current and appropriate activities. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.