

# Rosaria Rest Home 2006 Limited - Rosaria Rest Home

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## Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Rosaria Rest Home 2006 Limited
<b>Premises audited:</b>	Rosaria Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 19 September 2018    End date: 19 September 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	22

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	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

Rosaria Rest Home provides rest home level care for up to 26 residents. The service is privately owned and the owner/manager is supported by an assistant manager who oversees non clinical aspects of the business and a registered nurse who oversees clinical care. 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 review of policies and procedures, review of residents' and staff files, observations and interviews with management, residents and family members with assistance from an approved interpreter, and a general practitioner.

This audit identified one area requiring improvement relating to documentation of corrective action planning. Improvements have been made to complaints management, policies and procedures, two areas of medication management, kitchen hygiene, testing of biomedical equipment, and three areas of restraint management, addressing all areas identified for improvement in the previous audit.

## 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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There are adequate communication systems to ensure effective communication between staff and residents and their families and with other health providers. There is evidence that family are notified as and when required. There are appropriate processes in place to access interpreting services.

The complaints register sighted is up to date and shows that complaints are resolved promptly and effectively.

## 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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. The values and mission statements are displayed in English and Chinese. Monitoring of the services is undertaken by the owner/manager who attends all staff meetings and reviews all quality data findings monthly. He is assisted by a registered nurse and an assistant manager. The registered nurse oversees all aspects of clinical care and has been in the role over two years. She has 14 years' experience as a registered nurse overseas. The assistant manager has worked at the facility over three years and oversees non-clinical aspects of service. Regular education and training is undertaken by all three team members.

The quality and risk management system includes 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.

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Long and short term care plans are developed and evaluated in a timely manner. Interventions are sufficiently detailed to address the care needs. Short term care plans are developed when problems are identified and interventions are documented.

Planned activities are appropriate to the needs, age and culture of the residents who reported via the interpreter that activities are meaningful to them.

The medicine management system meets the required regulations and guidelines. Medication competencies are completed annually.

Food services meet food safety requirements and legislation. The individual food, fluids and nutritional needs of the residents are met.

## 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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There is a current building warrant of fitness and equipment has been checked by an approved provider.

## 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 a restraint free environment. No enablers or restraints were in use at the time of audit. Policy includes a comprehensive assessment, approval and monitoring process which identifies that regular reviews will occur should restraint be implemented. Policy shows that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and 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.
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Infection control surveillance activities are appropriate to the size and scope of the service.

## 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	18	0	1	0	0	0
Criteria	0	41	0	1	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
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints/concerns policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The improvement required identified in the previous audit relating to the complaints register not being up to date has been fully addressed by the service. The complaints register reviewed showed that two complaints have been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within the required timeframes. The documentation showed any follow up and that improvements have been made where possible. The owner/manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There has been one anonymous complaint made to the Auckland District Health Board (ADHB) covering various issues. This occurred in May 2018. All issues were investigated by the ADHB and none were substantiated. The complaint was closed on the 25 June 2018.</p>
Standard 1.1.9: Communication  Service providers	FA	<p>A district health board interpreter was available for this spot surveillance audit to assist with the interviews of residents and families. Residents and family members interviewed stated they were kept well informed about any changes to their/their relative's health status and were advised in a timely manner about any incident or accidents</p>



communicate effectively with consumers and provide an environment conducive to effective communication.		<p>that occurred. This was supported in the resident's records reviewed. Staff interviewed understood the principles of open disclosure. The service has an open disclosure policy which was reviewed and met the requirements of this standard.</p> <p>Staff knew how to access interpreter services although reported this was really required as all residents were Chinese and most of the staff were able to provide interpretation as and when needed and family could assist as required. The one non-Chinese speaking staff member was always on shift with another staff member to assist with any communication issues.</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>	FA	<p>The strategic, risk and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. The owner/manager, who has owned the facility for 12 years, attends all staff meetings and reviews the monthly quality data results to ensure he has oversight of all issues that arise. Reports sighted covered annual objectives, audits, clinical data, complaints, staffing, emerging risks and issues. The owner/manager works at the facility at least two days a week and is available to staff, residents and families at all times via phone.</p> <p>The assistant manager who has worked at the facility for over three years attends in-service education and the registered nurse has a current nursing annual practising certificate and holds relevant qualifications. She has been in the role for over two years and reports verbally to the owner/manager daily should any concerns arise. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The owner/manager and registered nurse confirmed their knowledge of the sector, regulatory and reporting requirements, and maintain currency through regular on-site and off-site education and training. All members of the management team speak Mandarin and can converse with their residents who all have limited English.</p> <p>The service holds an Age Related Residential Care (ARRC) contract with ADHB for rest home level care. All 22 residents were receiving services under the ARCC contract at the time of audit. The service also had three private paying boarders who were not included in this audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	PA Low	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections, wounds and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and implementing corrective actions as required. Staff are informed of corrective actions during daily shift handover and the registered nurse ensures they occur. The actions taken are shown on care plans and the outcomes of the actions taken are documented in resident's clinical notes. The service</p>

and risk management system that reflects continuous quality improvement principles.		<p>does not use the specific corrective action form available in policy therefore it is difficult to see all the actions taken related to non-clinical events such as response to audit findings. The owner/manager and the registered nurse can verbalise the actions taken but they are not always documented. Resident and family satisfaction surveys are completed annually. The most recent survey (August 2018) responses were all either satisfied or very satisfied with no negative comments made. The minutes from the six monthly residents' meetings confirmed residents had no concerns. This was supported during resident and family interviews undertaken at the time of audit with assistance of an interpreter. An annual questionnaire is also completed by residents related to the performance and satisfaction of the pharmacy, activities, podiatrist and GP. All comments were positive.</p> <p>The previous audit identified that not all policies and procedures were up to date. These have been updated and this issue has been addressed by the service to meet requirements. Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are developed by an off-site company and are based on current best practice. The service personalises the policies and procedures. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The assistant manager and owner/manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register is up to date and includes identification and management of hazardous substances. The owner/manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated and corrective actions were shown on the form and documented in residents' files showing that actions were followed up in a timely manner. Adverse event data is collated, analysed and reported at staff meetings. The information presented at staff meetings is analysed and trended against previously collected data. Negative trends in are addressed and documented. The owner/manager is kept informed of all incident and accident events.</p> <p>The owner/manager and registered nurse described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no police investigations, coroner's inquests, issues based audits and any other notifications such as infection outbreaks 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 requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and then annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff education occurs on-site monthly and off-site education is advertised and available to staff. The registered nurse verbalised that if she is unsure of anything she gains one on one assistance from the ADHB gerontology nurse specialist. Her portfolio identifies that she attends on-site and off-site education including the annual RN study day provided by ADHB. The registered nurse is trained and competent and maintaining her annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals for interRAI.</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>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. There is registered nurse coverage five days a week on morning shift and then on call after hours.</p> <p>The activities coordinator undertakes dedicated activities for two and half hours per day and staff follow the documented activities plan at other times. A dedicated cook works 7.30am to 1pm and 3pm to 6pm. seven days a week.</p> <p>Laundry and cleaning is part of the caregivers daily routine.</p>
<p>Standard 1.3.12: Medicine</p>	FA	<p>The medicine management system is implemented that complies with current legislative requirements and safe practice guidelines. Allergies and sensitivities are documented. Medication records are reviewed three monthly. Weekly checks of medication and six monthly audits are conducted. No controlled drugs are kept on site at this</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>facility. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are securely stored. The medication trolley is stored in a locked cupboard when not in use.</p> <p>Administration of medication was observed and confirmed safely and competency. Five senior care staff and the one registered nurse complete annual medication competencies.</p> <p>Medication records were reviewed, and information was recorded to a level of detail to comply with legislative requirements and guidelines in place, including for as required (pro re nata) medications. This was an area of improvement from the previous audit which has been addressed.</p> <p>No residents were self-administering medications at the time of the audit. Processes are in place should this be required. This was an area identified for improvement from the previous audit which has also been addressed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals are prepared and cooked on site. The dining area is located close to the kitchen. The menu is reviewed by a dietitian every two years. A range of foods are prepared to suite the residents' needs. The dietary profile is completed by the registered nurse as part of the entry assessments. Food service policies and procedures include food safety, ordering, storage, cooking, reheating and food handling. A system is in place when receiving and utilising kitchen supplies. The cook interviewed has current food safety certificates which were validated. A kitchen cleaning schedule is developed and implemented, addressing a previous area requiring improvement.</p> <p>Fridge and food temperatures are recorded daily. In addition to this, any fridges in residents' rooms are monitored. Monitoring records were reviewed to ensure compliance with safe food and hygiene requirements. This was an area for improvement from the previous audit which has been addressed.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. Dietary supplementary requirements can be arranged if required. The meals are well presented and the residents reported through the interpreter that they are provided with choices. Residents are weighed routinely. The facility manager has registered the organisation with a large aged care organisation and is working towards meeting the required food safety plan requirements.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	FA	<p>Residents' care plans are developed by the registered nurse who has completed the relevant interRAI training and competencies annually. Interventions are sufficiently detailed to address the desired goals/outcomes. Documented interventions are practical and staff reported that care plans are easy to follow. Monitoring forms are in use as applicable, such as weight, vital signs, wounds and behaviour. Wound assessment, monitoring and wound management plans are in place as required. The registered nurse has access to specialist services when needed.</p>

assessed needs and desired outcomes.		
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Activities provided are appropriate to the needs, age and culture of the residents. Activities are developed by the activities coordinator. Activities are developed using the residents' profiles gathered during interview with the residents and their families. Weekly activities are posted in the common areas. The Rosaria Rest Home activity schedule is documented in Chinese and English. The activity plan reflected the residents' activities and previous interests. An attendance register is maintained, and residents referred to the registered nurse if changes are noted. Interviewed residents and family members reported that activities are physically and mentally stimulating. Tai Chi is enjoyed by all residents two afternoons a week with an experienced instructor. All other activities provided are meaningful to the residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The long term care plans and short term care plans are evaluated six monthly or earlier if required. Evaluations consider the resident's degree of achievement towards meeting the desired outcomes for each need identified. Changes in the interventions in both long and short term care plans are made when goals are not achieved. Resolutions were documented in the short term care plans reviewed. Family input was noted on the long term care plans.</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>A current building warrant of fitness (expiry date 22 June 2019) is publicly displayed.</p> <p>The previous audit identified that bio-medical equipment tests were not current. This has been fully addressed by the service and the calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with the owner/manager and the registered nurse and observation of the environment.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for</p>	FA	<p>Infection control data is collected and collated monthly and analysed to identify any significant trends or possible causative factors. Incidents of infections are presented at the quality assurance and staff meetings. The necessary corrective actions are discussed. Incidents of infection were graphed and on display for staff. A comparison of</p>

infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		previous infection rates is used to analyse the effectiveness of the programme.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management and education in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, the facility was restraint free with no residents having either restraint or enablers. The last restraint used ceased on 11 August 2017. Policy identifies that enablers are the least restrictive and used voluntarily at their request.</p> <p>The registered nurse coordinator confirmed that restraint would only be used as a last resort when all alternatives have been explored.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The previous audit identified that an assessment was not carried out prior to restraint use. This has been fully addressed by the service. The restraint coordinator (RN) verbalised their awareness of the need for assessments to be carried out prior to restraint use. Assessment documents located in the restraint policy and procedure manual included all requirements of the Standard. The initial assessment would include the resident and family members. The restraint coordinator interviewed described the documented process. (As the facility was restraint free at the time of audit no completed documentation was sighted).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The previous audit identified that no monitoring was occurring when restraint was in use. The restraint coordinator verbalised her awareness to ensure the frequency of monitoring for restraint, should it be used, and that monitoring would be undertaken according to the resident's level of risk.</p> <p>Monitoring forms are available in policy and procedures. Documentation sighted, including the restraint register and staff meeting minutes, identified that the facility has been restraint free since August 2017. This was confirmed during staff interviews.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The previous audit identified that that restraint reviews did not cover policy compliance requirements. This issue has been addressed by the service. Six monthly review reports sighted identified that no restraint has been used since August 2017. The restraint compliance audit, last undertaken in January 2018, gained a 100% compliance rating. All policies and procedures sighted were current. Staff are informed of any changes to policies, guidelines, education and processes during staff meetings. Restraint annual education which was last presented in August 2018.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective action planning is undertaken to improve services as required. However, not all corrective actions taken are documented. There is a specific corrective action form available in the policy manual which is not being used by the service. Incident and accident corrective actions are shown on the form and in residents' notes and care plans, and complaints management follow up is documented in the complaints register. Whilst audit findings are shown on the audit form and the owner/manager verbalised the actions taken to address any issues found, corrective actions are not always documented. For example, one issue identified related to residents requesting a printed meal menu. Evidence of the printed menu was located on the residents' notice board which confirmed follow up had occurred but this was not documented.</p>	<p>The service does not use the corrective action form document in the policy manual, and at the time of audit, documentation could not be found for all corrective actions undertaken.</p>	<p>Provide evidence that all corrective actions are documented to show how issues have been addressed.</p> <p>180 days</p>





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

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

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

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

No data to display
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End of the report.