

Presbyterian Support Services (South Canterbury) Incorporated - Wallingford Rest Home

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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:	Presbyterian Support Services (South Canterbury) Incorporated		
Premises audited:	Wallingford Rest Home		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 23 January 2020	End date: 24 January 2020	
Proposed changes to current services (if any): None			
Total beds occupied across all premises included in the audit on the first day of the audit: 30			

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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

Wallingford Rest Home is one of three residential aged care facilities owned and operated by the Presbyterian Support South Canterbury (PSSC) organisation. Wallingford Rest Home is managed by a registered nurse who reports to the PSSC management team and is also supported by an administration/care manager, four registered nurses, and Wallingford Rest Home care staff. The service is certified to provide care to up to 32 rest home level care residents. There were 30 residents on the days of audit. Family and residents interviewed spoke positively about the care and support provided.

This surveillance audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The service has maintained continuous improvement in the area of planned activities.

The service has addressed two of the four previous certification audit findings around adverse events and care planning timeframes. Further improvements are required around meeting minutes and care evaluations.

This audit identified areas for improvement around wound care documentation.

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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Communication with residents and families is maintained and this was confirmed on interviews. A system of complaints is available to service users. Complaints and concerns have been managed 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 medium or high risk and/or unattained and of low risk.
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Wallingford has implemented the Eden Alternative philosophy of person-centred approach to care. The PSSC management team provide governance and support to the manager. The quality and risk management programme for PSSC includes service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Regional meetings are held monthly to discuss quality and risk management processes. Residents meetings are held, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Registered nurses are responsible for care plan documentation and this process is overseen by the clinical manager. InterRAI assessments were completed within required timeframes. Plans demonstrated service integration and are evaluated six monthly. Short-term care plans are in use for changes in health status. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and families reported the programme is varied, interesting and involves the community. The service uses an electronic medication management system. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Residents interviewed responded favourably to the meals provided.

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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Wallingford Rest Home has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Hot water temperatures are monitored and recorded.

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 actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There were no residents using enablers and no residents using restraint.

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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Wallingford continues to implement their infection surveillance programme. Infection control issues were discussed at infection control and quality meetings. The infection control programme is linked with the quality programme and benchmarked by an international benchmarking service.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation.

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	1	12	0	1	2	0	0
Criteria	1	37	0	1	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of the complaints process. There is a complaints form available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register. There have been no complaints since the last audit. The nurse manager on interview confirmed all complaints are investigated and corrective actions identified. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	<p>Five residents and four family members interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed included a section to record family notification. All ten forms sampled indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status.</p>

conducive to effective communication.		
<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>Wallingford Rest Home is part of the Presbyterian Support South Canterbury (PSSC) organisation and provides care for up to 32 rest home level residents. At the time of the audit there were 30 rest home residents in total, including one resident on respite care. Two beds are permanently allocated for respite residents.</p> <p>The nurse manager is a registered nurse and maintains an annual practising certificate. She has been in the role for eight and a half years. She is supported by an administration/care manager, four RNs, care staff and PSSC management team including the general manager for services for older people and the chief executive officer (CEO).</p> <p>Presbyterian Support South Canterbury has an overall organisation quality plan 2018-2020 in place with specific quality initiatives conducted at Wallingford. The organisation has a philosophy of care which includes a mission statement. The Eden Alternative philosophy of care is an important part of the organisation, which is understood and implemented by all members of the organisation including the Board. The principles of addressing helplessness, boredom and loneliness are incorporated in the cares provided and in the activities programme. The service aims to maintain an environment which is as home-like as possible.</p> <p>The nurse manager has completed in excess of eight hour's professional development in the past twelve months.</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 principles.</p>	PA Moderate	<p>Presbyterian Support South Canterbury has an organisational quality plan that includes quality goals and risk management plans for Wallingford. The quality and risk management programme is designed to monitor contractual and standards compliance. Quality data trends analysis related to incident and accidents, infection control, restraint and complaints are collected. There is a monthly continuous quality improvement (CQI) meeting for all three PSSC facilities where trends and benchmarking are reviewed. Staff meetings are held bi-monthly however, there was minimal documented evidence that meeting minutes included discussion around quality data trends analysis and what actions were required by staff. The previous finding around meeting minutes has not been addressed. Resident/relative meetings occur quarterly. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement. The service has a health and safety management system. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. There are designated health and safety staff representatives.</p> <p>A resident survey and a family survey are conducted bi-annually. The surveys evidence that residents and families are very satisfied with the service. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident lifestyle support plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. Falls prevention strategies include falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks,</p>

		correct seating, increased supervision and monitoring and sensor mats if required.
<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>There is an accident/incident reporting policy that includes definitions and outlines responsibilities. Ten accident/incident forms for the months of December 2019 and January 2020 were reviewed. All document timely RN review and follow-up. There was documented evidence of neurological observations being completed as per the policy. The previous finding around neurological observations has been addressed. Incidents are included in the PSSC continuous quality improvement programme, however, there was no documented evidence that staff meeting minutes included discussion around quality data trends analysis and what actions were required by staff (link 1.2.3.6).</p> <p>Discussions with the nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications made since the last 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>There are human resources policies to support recruitment practices. Current practising certificates were sighted for all health professionals working on site. Five staff files (two registered nurses and three caregivers) randomly selected for review had relevant documentation relating to employment. A copy of practising certificates is kept. Annual appraisals are conducted for all staff. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. There is a minimum of one care staff with a current first aid certificate on every shift.</p> <p>There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. Education records reviewed for 2018 and 2019 evidenced that training has been provided by way of education sessions and toolbox talks. The planner for 2020 is being implemented. The nurse manager and registered nurses are able to attend external training including conferences, seminars and sessions provided by PSSC. Caregivers have completed an aged care education programme. Staff attend an annual compulsory study day which includes training around the Eden Alternative programme. All four RNs have completed interRAI training.</p>
Standard 1.2.8: Service Provider	FA	Presbyterian Support South Canterbury policy includes rationale for staff rostering and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. A staff availability list ensures that staff sickness and

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>vacant shifts are covered. The nurse manager and RNs are available on call 24/7 for any emergency issues or clinical support.</p> <p>There were 30 rest home level care residents at the time of the audit. There is one RN on the morning shift and three caregivers (two long and one short shifts) on morning shift, three caregivers (two long and one short shifts) on the afternoon shift and two caregivers on night shift. The full-time nurse manager maintains her nursing registration. Core care staffing was reported as stable with some staff having worked at Wallingford Rest Home for over 14 years.</p> <p>Interviews with staff, residents and family identified that staffing is adequate to meet the needs 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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The facility uses an electronic medication management system. All medicines are appropriately stored in accordance with relevant guidelines and legislation. A registered nurse checks all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy. The medication room was clean, well-organised and room and fridge temperatures monitored daily and these were within acceptable ranges. The medication round observed during the audit was completed correctly.</p> <p>Registered nurses and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. Caregivers who act as second checker have also completed medication competencies.</p> <p>Electronic records for 12 residents demonstrated residents had been reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all electronic medication charts reviewed. As required' medication is reviewed by a registered nurse each time prior to administration.</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</p>	FA	<p>All meals are prepared and cooked on-site. A contracted food services manager oversees the kitchen staff. The service has a current verified food safety plan in place. Food services staff have attended food safety and chemical safety training. The menu has been reviewed by a dietitian. Cultural preferences and special diets are met. The cook receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated. Special diets are accommodated. The service has a buffet service for all meals as part of the Eden philosophy to allow residents food choices and maintain independence. Residents were observed at meal times independently or with assistance enjoying the buffet. Meals are delivered to residents in their rooms when required.</p> <p>Fridge and freezer temperatures are taken and recorded daily. End-cooked food and serving temperatures are recorded daily. Perishable foods sighted in all the fridges were dated. The dishwasher is checked regularly by the</p>

delivery.		<p>chemical supplier. Chemicals are stored safely. A maintenance and cleaning schedule is maintained.</p> <p>Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were very satisfied with the meals provided. Alternatives are offered for dislikes</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>	PA Moderate	<p>All five resident files reviewed included a lifestyle support plan. Support plans (including one respite resident) reviewed, included interventions that reflected the resident's current needs. When a resident's condition changes, the RN initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed stated there is adequate continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms were in place for four wounds (one skin tear, a chronic cracked heel, one stage one pressure injury and a chronic ulcer). Registered nurses interviewed were aware of when and how to get specialist wound advice and the district nurse practitioner had provided input around one wound.</p> <p>Not all wounds had a wound care plan and not all wound care documentation was complete.</p> <p>Monitoring charts were in place and examples sighted included (but were not limited to): weight and vital signs, blood glucose and pain as required.</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</p>	CI	<p>The activities coordinator (a qualified diversional therapist) provides a flexible activities programme over five days each week. The programme is planned monthly with significant resident input, and residents receive a personal copy of planned weekly activities. Activities planned for the day are displayed on noticeboards around the facility. An activity profile is completed on admission and a lifestyle activity plan is developed for each individual resident, based on assessed needs. Progress notes record any variances from normal activities daily and a weekly summary. Lifestyle plans were reviewed three to six monthly in files sampled. A folder with background information on each resident is available to staff. Specific information on each residents' interests, friends and family promote one to one relevant conversations. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The diversional therapist implements a programme based on the Eden Alternative which is aimed at reducing loneliness, helplessness and boredom.</p>

service.		Residents suggest a number of activities and these are compiled into a list. From this list residents choose which activities they would like to include in the next month's programme. A number of resident groups enjoy card games, knitting projects, gardening, jigsaws, choir and craft projects. Activities include visits from pre-school, primary and high school children, craft, baking and exercises. Families are encouraged to bring pets when visiting (as sighted on the day of audit). The service has a van that is used for resident outings. Volunteers from the local community assist with the activity programme. Residents and families interviewed were very positive about the variety of activities offered and the opportunities provided. The service continues to exceed the required outcome around activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	The registered nurses evaluate all initial care plans within three weeks of admission. Two of four care plans sampled demonstrated that the long-term care plan evaluation was comprehensive, related to each individual goal and detailed progress. One resident was a recent admission and did not require evaluation. The sample was extended to include a further three files. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Care plans sampled had been evaluated within the required timeframes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness which expires on 1 June 2020. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment and functional testing of electric beds and hoists. Hot water temperatures in resident areas are monitored and stable between 43-45 degrees Celsius. Contractors are available for essential services. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. Residents were able to access the outdoor gardens and courtyards safely. Seating and shade is provided. Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities,	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed on the electronic resident management system, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly facility infection summary and staff advise they are informed, although there is no documented evidence from meeting minutes (link 1.2.3.6). This data is monitored and

and methods that have been specified in the infection control programme.		evaluated three monthly and annually at infection control meetings. The infection control nurse advised that if there is an emergent issue, it is acted upon in a timely manner.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimized. There were no residents with restraints or enablers in place. The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence. Staff have been trained in the management of behaviours that challenge .

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Quality data trends analysis related to incident and accidents, infection control, restraint and complaints are collected. However, there was minimal documented evidence that staff meeting minutes included discussion around quality data trends analysis and what actions were required by staff.	One of six staff meeting minutes reviewed included minimal documented evidence that meetings included discussion around quality data trends analysis and no discussion of what actions were required by staff.	Ensure that staff meeting minutes include discussion of quality data trends analysis and actions required, if any. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to,	PA Moderate	Registered nurses are responsible to assess, and document residents needs in care plans and complete an assessment, plan and reviews (at the time of dressing changes) for wounds. Two of four wounds had a documented	i) Two of four wounds did not have a documented assessment. ii) Three of four wounds did not evidence dressings were completed at the frequency documented in the management plan. iii) One of four wounds did not have a documented	i) Ensure all wounds have a documented assessment when first identified. ii) Ensure all wounds are dressed at the frequency identified in the wound

meeting the consumers' assessed needs, and desired outcomes.		assessment. Three of four wounds had a documented management plan however the dressings did not also follow the documented plan. Evaluations were documented for two of four wounds.	management plan. iv) Two of four wounds did not have evaluations documented (RNs were documenting in the file progress notes, however recent deterioration changes and progress were not clearly identified.	management plan. iii) Ensure all wounds have a documented management plan. iv) Ensure that evaluations have been fully documented for wounds. 60 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	All four care plans that required routine six-monthly evaluations had been reviewed. One resident had not been at the service for six months. The sample was extended by a further three files. Three of the seven evaluations documented progress toward goals and desired outcomes.	Four of seven long-term care plans that had been evaluated did not document progress toward the desired outcomes.	Ensure that progress toward desired outcomes is documented when care plans are evaluated. 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
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.	CI	Wallingford Rest Home has provided a varied activities programme for many years. Initiatives in 2019 and 2020 have expanded on previous themes and the residents continue to have extensive input into both the development and delivery of the activities programme.	<p>Recent new initiatives have been implemented as a result of suggestions from resident focus groups. These include life tube project funded from a legacy. Tubes are designed to contain essential information for people who live alone. Residents at Wallingford Rest Home worked together and inserted a personal note from the person whose legacy provided 2000 tubes. These were then available for distribution to the community. A second initiative was observed on the day of audit. On discussion with residents, changes were made to the way deceased residents leave the facility. When a person dies at the home, all residents, visitors if they wish and staff form a guard of honour and participate in a farewell service as they leave. On the day of audit, family and residents' feedback was very positive.</p> <p>The resident suggestion list of twenty for 2020 includes planting seeds in pots and offering for sale, implementing a walker's group, snow trip, fish and chips at the bay, fishing from the wharf, mystery bus trips and making relish. Evidence of these were incorporated into the monthly planners.</p> <p>All residents interviewed stated the activities programme was meaningful and described an 'ownership' of the programme.</p>

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End of the report.