The Napier District Masonic Trust - Elmwood House and Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	The Napier District Masonic Trust
Premises audited:	Elmwood House and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 27 October 2020 End date: 27 October 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: 36

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

Elmwood House and Hospital provides hospital and secure dementia level care for up to 39 residents. The service is owned by the Napier Masonic District Trust Board. The facility is managed by a registered nurse. Management and administration support includes input from a clinical director, quality coordinator and administration support from the Trust Board.

Residents and families spoke positively about the care provided.

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

Areas for improvement identified at this audit related to complaints management, quality management, human resource management, the development of long-term care plans and interRAI assessments and reviews.

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.

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

The implemented complaints process is known by staff, residents and resident families.

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.

The board provides organisational governance functions. The general manager and clinical director have extensive experience in the health and disability sector. Both are supported by other organisational managers, clinical and support staff.

There is a documented and implemented quality and risk management programme. Quality data is collected and analysed for trends. There are policies and procedures to support provision of appropriate support to residents.

A staff training schedule is in place. Rosters, staff, resident and family interview indicate sufficient and appropriately skilled staff are available in the service.

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 complete initial assessments including interRAI assessments. The lifestyle care plans are individualised and tailored to residents clinical, lifestyle care and support needs. Short term care plans are developed and implemented for any short-term care needs. Resident's files sampled demonstrated there were personalised goals care planning with interventions and a review and evaluation of goals and care plans. Residents and families reported being kept well informed and involved in the care planning and evaluation process. Referrals are made by the general practitioner as needed and appropriate handovers are provided if a resident is transferred to another health service.

The planned activities programme is implemented by an activities coordinator and the programme provides residents with a variety of group and individual activities and maintains their link with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures and are consistently implemented using an electronic system. Medications are administered by competent staff all of whom have been assessed as competent to do so.

A food safety plan and policies to guide food service delivery are in place. Kitchen staff have food safety training and qualifications. The nutritional needs of the residents are met, and any special needs are identified and catered for. The kitchen is organised, clean, tidy and meets food safety standards. Residents and family interviewed verified satisfaction with the 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 buildings are suitable for the needs of residents with safe external areas. The building warrant of fitness is current and equipment regularly checked and calibrated. There have been no building alterations 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.

Policies and procedures are in place to support the minimisation of restraint. There were eleven restraints in use at the time of this audit and no enablers. Assessment, approval and monitoring processes with regular reviews occurs. Staff interviewed have good knowledge and understood the restraint and enabler processes and that the use of enablers is voluntary for the safety of the residents in response to individual requests.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection prevention and control programme is reviewed annually. The programme is implemented by the infection control coordinator, a registered nurse who aims to prevent and manage infections for this facility. Specialist infection prevention and control advice can be accessed as and when needed.

Staff interviewed demonstrated a sound knowledge of infection control principles and practice. Infection control is guided by relevant policies and supported with sound education. Resources and reference information is readily available.

Aged care appropriate surveillance is undertaken, and results are reported, and information is fed back to staff. Follow-up action is taken as and when required.

The facility had procedures in place to manage the Covid 19 pandemic. Staff had received additional education and guidance on the use of personal protective equipment and infection control and there was evidence of good supplies of personal protective equipment.

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	12	0	4	0	0	0
Criteria	0	36	0	4	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.	PA Low	There is a detailed complaints process set out in policy and aligns with Right 10 of the Code of Health and Disability Consumer Rights. The complaints process is detailed in the residents' welcome pack. Complaints forms are available at the front entrance area of the facility along with information on advocacy services available. Code of Rights information posters are also displayed on entrance area walls. A complaints register is maintained for both verbal and written concerns. Four complaints have been received since the last audit, two verbal and two written. Verbal complaint date and time and date of response only is recorded in the register. No detail of the verbal complaint is documented. The quality coordinator and clinical director are responsible for complaints and responding in writing. Complaint review is used to inform part of the quality process. Training records evidence staff receive education on the complaints process through internal training. Families interviewed confirmed that they felt able to raise concerns with staff and that managers responded within an appropriate timeframe. There has been one Health and Disability complaint related to quality of care since the last audit, generated by a resident's family member. Service documents reviewed evidenced appropriate processes had been followed to respond to the complainant and the Health and Disability Commission. Changes to care provision have been implemented to address issues raised in the complaint. The service is awaiting a response from the Commission.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Staff education has been provided related to appropriate communication methods. Resident files and family interviewed confirm residents and families are consulted and informed of any untoward event or change in care provision. Accident/incident forms sampled evidenced open disclosure. Policies and procedures are in place if interpreter or advocacy services are required. The GP interviewed reported satisfaction with communication from staff.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Napier District Masonic Trust (NDMT) commenced ownership and governance of Elmwood House and Hospital in 2014. The NDMT also owns and operates another facility in the Napier region. The strategic management plan included organisational goals, mission statement, values, vision and objectives defined in measurable terms. Board meeting minutes sampled confirmed that organisational performance is monitored through monthly reports from senior managers. The quality and risk management plan includes quality goals, progress towards achievement and risk, risk ratings and risk management strategies. There is a current health and safety and Maori culture responsiveness plan. The service is led by a general manager who reports directly to the board and is supported by the clinical director, quality coordinator, finance manager and facilities manager. Day to day service delivery is managed by the clinical director. The clinical director is a registered nurse who has been in the role since 2019 and has long-term experience in the aged care and health and disability sector. Elmwood House and Hospital is currently certified to provide 25 rest home dementia level beds and 14 hospital level beds. All dementia and hospital beds were occupied on the day of the audit. The facility has contracts with the District Health Board for aged-related resident care (continuing care, dementia care), and for long term support – chronic health conditions – LTS-CHC (long term hospital and dementia care, short term day care, rest home and dementia care). One of the residents with LTS-CHC was under 65 years. This client was receiving rest home level care in the dementia section. The facility also has contracts for respite and day care services for rest home, hospital and dementia level care. There were no clients receiving respite care and two clients using day care services at the time of the audit.
Standard 1.2.3: Quality And Risk Management Systems	PA Low	There is a documented and implemented quality and risk management plan, current to December 2020. The plan sets out quality goals and outlines action plans and progress towards achievement. Risks, responsibilities and controls are identified. Quality and risk are integrated in the strategic plan and other organisational systems. The

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		plan is reviewed annually. Service managers' report quality information is shared at regular staff meetings. There was no documented evidence to demonstrate this. The quality programme includes monitoring the implementation of policies and procedures, incidents/accidents, complaints, infection control, internal audits and health and safety. Data that is collected (e.g. client incidents, staff incidents, challenging behaviours), collated and analysed with results discussed at the quality meeting. Improvement opportunities are noted and monitored for effectiveness. A hazard identification and mitigation process is implemented. A schedule of internal audits is implemented. Internal audits monitor a range of services provided (e.g. health and safety, environmental, infection control, incidents/accidents/hazards, kitchen and food safety, complaints, advanced directives, medication management, pain management). Corrective actions are identified on the audit form where improvements are indicated. Corrective actions are signed off when completed. Policies and procedures are relevant to the facility and available to staff. There is a document control policy that is integrated into the quality system. All staff undergo health and safety training and there is a designated health and safety representative. The hazard register is regularly reviewed by the quality coordinator and updated as required.
Standard 1.2.4: Adverse Event Reporting 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.	FA	There is a system for reporting and managing adverse events. Staff record adverse, unplanned or untoward events on an incident/accident form. The quality coordinator collates and records incidents and reports on these to the quality meeting, general manager and the board. Ten incidents were reviewed and reflected that forms are completed in a comprehensive manner with sign off from the applicable member of staff. The clinical director and quality coordinator are aware of situations that require statutory reporting. There has been two Section 31 reports lodged since the last audit, related to a burst internal water pipe and resident assault of another resident.
Standard 1.2.7: Human Resource Management Human resource	PA Low	Human resource policies and procedures are in place and support good practice. There is a defined recruitment process. The clinical director and clinical coordinator are responsible for undertaking recruitment processes. Four of five staff files sampled (one diversional therapist, one registered nurse and three healthcare assistants) did not

management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		contain completed police vetting, reference checks or job descriptions. Files reviewed and staff interview evidence all new staff complete a comprehensive service orientation. A tailored service orientation has been developed and implemented for agency staff since the last audit. This previous finding is now closed. The in-service training programme includes a range of mandatory staff education requirements. Staff records sampled confirm educational requirements have been met. The programme includes, but is not limited to; medication, health and safety, first aid, advanced directives, infection prevention and control, cultural, communication, managing challenging behaviours, restraint, wound care and skin management. Registered nurse annual practicing certificates sighted were current. The clinical coordinator has completed interRAI training. Healthcare assistants are supported to achieve Level 4 Health and Wellbeing certification. Staff performance is monitored. This includes annual performance appraisals. The residents, families and general practitioner interviewed all reported satisfaction with the knowledge and skills of staff.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a staffing rationale policy. In both the dementia unit and the hospital, the rosters evidence that sufficient cover is provided on all duties. Numbers and skill mix address the layout of the facility in two adjoining wings with the dementia wing being secured. The activities coordinators (2 part-time staff) work across both the dementia house and the hospital. Group activities are encouraged in the dementia house on a daily basis. The activities provided in the hospital are more on a one to one basis but residents join in the group activities as able. Activities are provided by the activities coordinators five days a week. Registered nurses provide cover 24 hours a day, seven days a week in the hospital and the dementia wing. The dementia unit is staffed by a registered nurse (RN) every morning Monday to Friday with RN cover from the hospital at other times. RNs complete assessments, care plans and reviews. Sufficient health care assistants (HCAs) are allocated to the hospital and to the dementia wing to meet resident needs. HCAs interviewed reported that there are enough staff on duty and they were able to get through the work allocated to them. Additional staff are employed to maintain support services such as laundry, cleaning, activities, food services and maintenance. Families interviewed reported there are enough staff on duty to provide their relative with adequate care. Shifts are replaced in the event of staff absence. If the roster is unable to be filled by current staff, bureau staff are utilised. All replacements are recorded on the roster.
Standard 1.3.12: Medicine Management Consumers receive	FA	Registered nurses, and senior HCAs who administer medications have been assessed for competency on an annual basis. Registered nurses have completed syringe driver competency. Care staff interviewed described their role regarding medicine administration. Staff members observed administering medication demonstrated good

medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		knowledge and understanding of the role and responsibilities related to each stage of medication management. Medication reconciliation of blister packs is completed by an RN and any errors fed back to pharmacy. The services utilise an electronic system. The records of temperature monitoring for the medicine fridge and medication room were sighted and readings were within the recommended range. Ten medication charts were reviewed on the electronic medication system. Administration charts demonstrate that medication is being administered as prescribed. Medication charts met the legislative requirements for the prescribing of regular medications. All prescriptions for 'as required' medications document the indication for use. The three-monthly medication reviews by the GP are verified on the electronic record maintained. There were no self-medicating residents on the day of audit. In the event there are residents who manage their own medications there are systems and processes in place to ensure this is safely managed.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Menus are developed and implemented with summer and winter seasonal foods. The menu is reviewed by a dietitian. The service has a registered food control plan in place which expires 18th April 2021. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile is developed. The personal food preferences of the residents, special diets and modified nutritional requirements are provided to the cook and accommodated in the daily menu plan. Any diets or special needs are documented on the whiteboard sighted in the kitchen. There is snack food available for residents in the dementia section at all times. The kitchen was clean and tidy. Special equipment was available to meet the nutritional needs of the residents, this included lip plates, bowls and built-up cutlery. The cook is responsible for all aspects of food procurement, production, preparation, storage, deliveries and disposal and complies with all current legislation and guidelines. A kitchen cleaning schedule is developed and implemented. Evidence of resident satisfaction with meals is verified by residents and family interviews and there is a box where residents can provide written feedback. The dining room in the dementia service is located near the kitchen. The hospital residents have their meals in the lounge/dining area in the hospital wing. Staff and family members were sighted assisting residents as needed with their meals. The service is undertaking a nutrition review and kitchen review to improve the food and nutrition for residents. This has included a review of kitchen staffing, education to all staff, and implementation of a new fortified diet range for residents. The Quality Coordinator described the positive outcomes that have already been achieved from these programmes.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Resident's progress is documented in the clinical record and progress notes. Resident changes in condition are followed-up by a registered nurse as evidenced in residents' progress notes. The care plans reviewed documented interventions that reflected the resident's current needs. When a resident's condition changes, the RN initiates a GP visit or nursing specialist referral. The resident interviewed reported their needs were being met. The family members interviewed, and documentation reviewed confirmed that relatives had been notified of changes to their relative's health. There was documented evidence of relative contact for any changes to resident health status. Long-term care plans reflected all interventions required to meet the resident's goals and needs. Care plans were amended to reflect changes in health status. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care. Wound assessment, monitoring, wound management plans and short-term care plans are in place for wound care management. Wounds included two pressure injuries (one grade one and one grade two), basal cell carcinomas, a herpes wound and skin tears. The RNs have access to specialist nursing wound care management advice through the district health board (DHB). Appropriate pressure injury interventions were documented in the care plans of residents identified as high risk of pressure injury. Monitoring charts sighted were documented and included (but were not limited to), weight charts, repositioning charts and behaviour monitoring. Continence products and personal protective equipment (PPE) are available and were sighted. Caregivers and RNs interviewed state there is adequate continence, PPE and wound care supplies.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme at Elmwood House and Hospital is provided by a diversional therapist and activities coordinator with the support of the staff. Planned actives are provided seven days a week. Residents are assessed on admission to ascertain their needs and appropriate activities and social requirements. The resident leisure/lifestyle profiles are analysed to develop an activity programme that is meaningful to the residents. The planned monthly programme matches the skills, likes, dislikes and interests evidenced in the assessment information. Activities reflect residents' goals and interests. A van is available for community activities. Group activities are encouraged in the dementia service. Consideration of activities for the under 65-year olds in the dementia service are planned. Entertainment is planned, and there is a monthly calendar prepared and weekly activity calendars are displayed for families and residents with upcoming events. A variety of activities involving exercising, indoor bowls, quizzes, baking, news reading, and entertainers are provided. Family are involved when

		the lifestyle care plan is evaluated six monthly or earlier if required. The activities for the dementia service are available for the 24-hour period. There is an activities cupboard in the dementia section that staff can access at all times for resident activities. The activities provided in the hospital section are one to one activities, but residents can join group activities or entertainment events in the dementia section if they wish to. Attendance and participation records are documented. Evaluations occur on a one to one basis. On the day of the audit activities included news reading.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated each shift and reported in the progress records. If any changes occur the care staff report to the RN. Residents' lifestyle care plan evaluations occur six monthly or earlier if needs change. Where progress is different than expected the service is seen to respond by initiating changes to the plan. Evaluations were sighted in the sample of resident records reviewed. A short-term care plan is initiated for short term issues such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk verified during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness was displayed and current. Hot water temperatures are safe, monitored and recorded monthly. The testing and tagging of equipment and calibration of bio medical equipment is current.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been	FA	There is a policy for infection control surveillance. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the facility meetings. If there is evidence of any emerging trends or concerns this is acted upon in a timely manner. During the Covid 19 pandemic additional education was provided to staff, this has been ongoing. Education has included donning and doffing of personal protective equipment. Personal protective equipment supplies has included but is not limited to hand sanitisers, face shields, gloves, gowns and masks.

specified in the infection control programme.		There has been a Norovirus outbreak since the previous audit. The date for this outbreak was 16th November 2019 to 22nd November 2019. A total of 20 residents were affected (four residents from the hospital section and 16 residents from the dementia section). Ten staff members were affected. Changes to infection control processes that were implemented included additional education being provided to staff and additional personal protective equipment was provided. Staffing levels were increased for the afternoon and night shifts. Staff were separated with staff only working in the hospital section and other staff only working in the dementia section. Kitchen staff stayed in the kitchen and meals were collected from the kitchen. Cleaning responsibilities for each side were separated. Infection control processes were implemented in the laundry. The facility management team liaised with the Public Health Unit and District Health Board and stated they received good support.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint minimisation and safe practice policy reflects the requirements of the restraint minimisation and safe practice standard (NZS 8134:2008). The service's policy was understood by clinical staff interviewed and annual education is provided. Restraint is used as a last resort when all alternatives have been explored. The service had eleven restraints and no enablers in use in use at the time of audit. Restraints included the use of bed rails and chair support briefs. There was evidence that these were being monitored appropriately and there was a care plan in place in resident files sighted.

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 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	The service maintains a complaint register.	The complaints register does not include documented detail of verbal complaints received.	Ensure both written and verbal complaints are documented in the complaints register. 60 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 Low	Quality data is collected, analysed and trends identified.	There is no documented evidence confirming quality data is shared with staff.	Ensure quality data is routinely shared with all staff and this is documented.

				60 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Human resource policies and procedures are in place and support good practice. There is a defined recruitment process.	Four of five staff files sampled did not contain completed police vetting, reference checks or job descriptions.	Ensure all required recruitment processes are completed and documented in staff files. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Long-term care plans were evident in all files sampled. Registered nurses complete interRAI assessments and long-term care plans. The facility has four RNs trained to undertake interRAI assessments.	(i) There were two resident files of the five files sampled that did not have care plans developed within the required time frame. (ii) There were three resident files (of the five files sampled) where initial interRAI assessments had not been completed within the required time frames. (iii) Four residents were overdue for their interRAI reviews.	(i) Ensure all long-term care plans are completed within the required time frames. (ii) Ensure all initial interRAI assessments are completed within the required time frames. (iii) Ensure all interRAI reviews are completed within the required time frames. 60 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, these 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.