

# Jean Sandel Retirement Village Limited

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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 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:

<b>Legal entity:</b>	Jean Sandel Retirement Village Limited
<b>Premises audited:</b>	Jean Sandel Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 26 April 2017    End date: 27 April 2017
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	109

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

## General overview of the audit

Jean Sandel is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital and dementia level of care for up to 112 residents in the care centre and rest home level of care for up to 20 residents in serviced apartments. On the day of audit, there were 109 residents in the care centre. There were no rest home residents in the serviced apartments. The service is managed by an experienced village manager who is a registered nurse.

The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and the general practitioner.

This audit has identified an area for improvement was identified around admission visits and interventions.

Continuous improvement has been maintained around food services.

## 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 is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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.		Standards applicable to this service fully attained.
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Services are planned, coordinated and are appropriate to the needs of the residents. A village manager, assistant manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is implemented for new staff. Ongoing education and training includes in-service education and competency assessments. Registered nursing cover is provided 24 hours, 7 days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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InterRAI assessments, risk assessments, care plans and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. The general practitioner completes reviews the residents at least three-monthly.

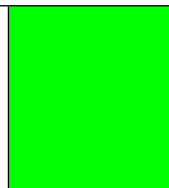
The activity team provide an Engage activities programme which is varied and interesting. The Engage programme meets the abilities and recreational needs of the rest home, hospital and dementia care residents including a men's group.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

The menu is designed by a dietitian at an organisational level. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food that is 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.

The building has a current warrant of fitness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

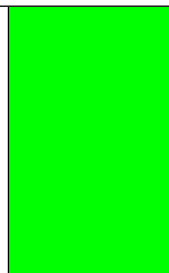


Standards applicable to this service fully attained.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with restraint and no residents with an enabler at the time of the audit.

## 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 includes policies and procedures for the surveillance of infections. The infection prevention and control team holds integrated meetings with the health and safety team. A monthly infection control report is completed monthly and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. The service has had one outbreak since the last audit that was well managed.

## 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	13	0	1	1	0	0
Criteria	1	38	0	1	1	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy is being implemented at Jean Sandel. The village manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. The facility has an up-to-date complaint register. Concerns and complaints are discussed at relevant meetings. There were five documented complaints made in 2016 and no complaints received in 2017 year to date. Follow-up letters, investigation and outcome was documented. Corrective actions have been implemented and any changes required were made as a result of the complaint. Interviews with residents and relatives confirmed they were provided with information on the complaints process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. The incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Fourteen incident forms reviewed for March 2017 identified that family were notified following a resident incident. Interpreter policy and contact details of interpreters is available. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Three relatives interviewed (one rest home and two dementia) stated that they are informed when their family members health status changes. The information pack is available in large print and this can be read to residents. The information pack and admission agreement included payment for items not included in the services.</p>



<p>conducive to effective communication.</p>		<p>Five residents (three rest home and two hospital) interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. A specific introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Jean Sandel is a Ryman Healthcare retirement village providing rest home, hospital and dementia level care for up to 132 residents. This includes 39 rest home level beds, 51 dual-purpose beds, 22 dementia level beds and 20 serviced apartments certified as able to provide rest home level care. There were no residents receiving rest home care in the serviced apartments on the day of audit.</p> <p>Occupancy during the audit was 39 rest home residents in the ground floor rest home. In the hospital on level 1, there was 16 rest home residents and 34 hospital level residents in the 51 dual-purpose beds and 22 residents in the 22-bed dementia unit.</p> <p>There were no residents on respite care and no residents under the medical services of care.</p> <p>There is a documented service philosophy developed at head office that guides quality improvement and risk management in the service. Specific values have been determined for the facility. The village quality objectives and quality initiatives for 2017 have been set, with evidence of monthly reviews and quarterly reporting to head office on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions around the 2017 objectives.</p> <p>The village manager at Jean Sandel has been in the role since August 2015 and has a background in facility and regional management in aged care. She is supported by an assistant manager, who carries out administrative functions and a clinical manager who oversees clinical care and support for the village manager. The clinical manager been in the position for three months. The wider Ryman management team that included a regional manager, supports the management team. The village manager has maintained at least eight hours of professional development activities related to managing a village.</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</p>	<p>FA</p>	<p>Jean Sandel has a well-established quality and risk management system that is directed by Ryman head office. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team (village manager, assistant manager and clinical manager) and staff and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities. Family meetings are held six-monthly and residents' meetings are held every two months. Minutes are maintained. Annual resident and relative surveys are completed. Quality improvement plans are completed with evidence that suggestions and concerns are addressed.</p> <p>The service has policies, procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. These are communicated to staff, as evidenced in staff meeting minutes and sighted on the staff noticeboards.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. There are clear guidelines and templates for reporting. Management systems, policies and procedures are developed, implemented and regularly reviewed. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. The service has exceeded the required standard in this area. Falls prevention strategies are in place that include: hi/lo beds; ongoing falls assessment and exercises by the physiotherapist; sensor mats; fall prevention pamphlets; and appropriate footwear.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety meetings. A health and safety representative (caregiver) is appointed who has completed health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. The hazard identification resolution plan is sent to head office and identifies any new hazards. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of fourteen incident/accident forms from across all areas of the service, identified that all are fully completed and include follow up by a registered nurse (RN). The clinical manager is involved in the adverse event process, with links to the applicable meetings (teamRyman, RN, care staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur. The village manager is able to identify situations that would be reported to statutory authorities.</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>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one clinical manager, one clinical leader, one hospital unit coordinator, two RNs, three caregivers and one activities coordinator) provided evidence of signed contracts, job descriptions relevant to the role the staff member is in, induction, application form and reference checks. Staff files reviewed included annual performance appraisals with eight week reviews completed for newly appointed staff.</p> <p>A register of RN and enrolled nurse (EN) practising certificates are maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration. An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Twelve care assistants work in the dementia unit. All twelve care assistants have completed their dementia qualification.</p> <p>Registered nurses are supported to maintain their professional competency. Staff training records are maintained. There are implemented competencies for RNs, ENs and care assistants related to specialised procedures or treatments including medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The care centre is overseen by a full-time clinical manager. Each service unit in the care centre has a full-time RN unit coordinator. There is at least one RN and first aid trained member of staff on every shift. Interviews with care assistants informed the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs. Agency staff can be used to cover unexpected absences. The village manager and clinical manager, work full-time Monday to Friday and are on call 24/7.</p> <p>Staffing is as follows: in the rest home unit (39 residents) AM shift: one RN, four caregivers; PM shift: three caregivers; and night shift: two caregivers (the RN in the hospital oversee the rest home unit in the PM and night shifts). In the hospital unit (36 hospital and 13 rest home residents): AM shift: two RNs, nine caregivers; PM shift: two RNs, seven caregivers; and night shift: one RN, three caregivers.</p> <p>In the dementia unit (21 residents): AM shift: one RN, two caregivers; PM shift: three caregivers (including one lounge carer); and night shift: two caregivers (the two RN's in the hospital oversee the dementia unit in the PM and night shifts).</p> <p>There is a specific roster for the serviced apartments when there are rest home residents living there.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medication reconciliation is completed by RN unit coordinator or enrolled nurse. The backs of the blister packs were signed by the nurse checking the pack. Registered nurses, enrolled nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored weekly.</p> <p>Standing orders are not used. Six self-medicating residents in the rest home had been assessed and reviewed by the GP and RN as competent to self-administer.</p> <p>Fourteen medication charts were reviewed on the electronic medication system. All medication charts reviewed have 'as required' medications prescribed with an indication for use. The effectiveness of 'as required' medications are entered into the electronic medication system.</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>	<p>CI</p>	<p>All food and baking is prepared and cooked on-site. The qualified chef is supported by cook and kitchen assistants. All staff have been trained in food safety and chemical safety. There is an organisational four-weekly seasonal menu that had been designed in consultation with the company chef and the dietitian at organisational level. The reviewed menu includes more meal choices for the midday meal and dinner.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes such as residents with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such pureed/soft, diabetic desserts, vegetarian and gluten free are provided. There are nutritional snacks available 24 hours.</p> <p>Freezer and chiller temperatures and end cooked temperatures are taken and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from daily resident contact resident, resident meetings, surveys and audits.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services</p>	<p>PA Moderate</p>	<p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required, a GP visit or nurse specialist consultant. Not all care plans had been updated to reflect the changes in resident needs/supports. Short-term care plans are developed for infections.</p> <p>Wound assessments, treatment and evaluations were in place for residents with wounds (eleven hospital, seven rest home and two dementia care) including three facility acquired pressure injuries (two stage I and one stage II).</p>

<p>in order to meet their assessed needs and desired outcomes.</p>		<p>The pressure injuries had not been linked to the long-term care plans. Adequate dressing supplies were sighted in the treatment rooms. The service has access to the DHB wound nurse as required, however, the podiatrist recommendation for referral to the wound nurse had not been followed up.</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.</p> <p>Monitoring forms in place include (but not limited to): monthly weight; blood pressure and pulse; neurological observations post unwitnessed falls or identified head injuries; food and fluid charts; restraint monitoring; pain monitoring; blood sugar levels; and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a team of activities coordinators to coordinate and deliver the Engage programme across the rest home, hospital and dementia care units. An activity coordinator is based in the rest home Monday to Friday. There is an activity coordinator and activity assistant based in the hospital to provide group and one-to-one activities seven days a week. Two activity coordinators (one a diversional therapist and the other has dementia unit standards) share the seven-day week activity role in the dementia unit.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group. Activities include: sensational senses; triple A exercises; walks; baking; word games; news and views; and musical moments. There are adequate resources available. Daily contact is made with residents who choose not to be involved in the activity programme. The men's group meet fortnightly and include activities such as building bird houses.</p> <p>Regular interdenominational church services are held on-site. Community visitors include entertainers, speakers and animal visits.</p> <p>Life experience forms are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident/relative meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>Five of seven care plans reviewed had been evaluated by registered nurses' six-monthly. Two residents (one rest home and one hospital) had not been at the service six months. Written evaluations describe the resident's progress against the residents identified goals. The multidisciplinary review involves the RN, GP, activities staff and resident/family and other allied health professionals involved in the care of the resident. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews</p>

comprehensive and timely manner.		and GP visits.
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 building has a current building warrant of fitness that expires 24 January 2018.
Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed on the electronic system for all infections. Infections are included on an electronic register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined infection prevention and control and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility. A six-monthly trends analysis is completed and benchmarked against organisational key performance indicators for types of infection events. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>A norovirus outbreak January 2017 was well managed and included a debrief meeting to review overall management by staff and followed up with ongoing education. Relevant authorities were notified.</p>
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraint and no residents using an enabler. Staff training has been provided around restraint minimisation and enablers, falls prevention and management of challenging behaviours.



## 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 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	PA Low	The GP reviews the residents at least three-monthly. Admission visits for four resident files reviewed were within two working days. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status.	GP admission visits for three residents (one rest home, one hospital and one dementia care) admitted from the community were outside of the required two working days.	<p>Ensure new residents are admitted by the GP within two working days when admitted from the community.</p> <p>90 days</p>



<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>There were wound assessments and ongoing evaluations sighted (on the V-care system) for current wounds and three pressure injuries. However, the care plans had not been updated to reflect a pressure injury. Allied health professionals who were involved in the care of two residents made recommendations that have not been implemented. Care plans for three of seven resident files reviewed were current and up to date.</p>	<p>(j)The care plans for three residents with facility acquired pressure injuries had not been updated to include the pressure injury and nursing cares required; (ii) The podiatrist made a recommendation for a rest home resident to be seen by the wound nurse for a stage I pressure injury of toe. There was no evidence of a referral or action taken. The physiotherapist recommended the trial of hip protectors for a rest home resident post falls with injury. There was no evidence of follow up of physiotherapist recommendation; (iii) The care plans for the same rest home resident had not been updated to include a) health status following a hospital admission; and b) the falls risk had not been identified on the long-term care plan or reviewed post two falls with injury.</p>	<p>(i) Ensure pressure injuries and interventions are linked to the long-term care plans; (ii) Ensure recommendations made by allied health professionals are followed up and implemented and; (iii) Ensure all care plans are updated to reflect the resident's current health status.</p> <p>60 days</p>
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## 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, these 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
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the</p>	CI	<p>In November 2016, the menu was reviewed to include more choice of meals at the midday meal and dinner. The service has continued to improve its choices of pureed meals including pureed desserts.</p>	<p>The service has introduced meal choices on four of the seven week days. This will be increased to seven days a week with the employment of another chef. There are three meal choices at the midday meal including a vegetarian option. There are two dessert options one of which is suitable for diabetics. The evening meal provides two options. Residents complete daily menus which ensure choices are catered for. There has been a focus on improving the pureed meals and these are now the same as the menu, although some vegetables may vary but the meats are the same. There is continued weight monitoring of those residents on pureed meals. Documented evidence of ten residents on pureed meals have gained one to three kgs over the last one to three months. There is continuing feedback and discussion around meals through regular meetings and surveys. Concerns raised have been actioned. Residents and relative interviewed on the day of audit commented positively on the meals provided which has been validated in survey results and meeting minutes. The service has continued to improve the meal service.</p>

consumer group.			
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End of the report.