

# North Waikato Care of the Aged Trust Board - Kimihia Home & Hospital

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	North Waikato Care of the Aged Trust Board
<b>Premises audited:</b>	Kimihia Home & Hospital
<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: 14 August 2019 End date: 15 August 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	63

# 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

Kimihia Home and Hospital provides rest home, secure (dementia care) and hospital level care for up to a maximum of 78 residents.

The service is owned and operated by the North Waikato Care of the Aged Trust Board and managed by a Facility Manager (FM) who is a registered nurse (RN). The FM is supported by two Clinical Nurse Managers (CNMs).

The FM advised there have been no significant changes to the service and facilities since the previous audit.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, visiting mental health practitioners and a general practitioner. All interviewees spoke positively about the care and services provided.

Evidence of actions to rectify the three findings from the previous audit were assessed, and all of those non-conformances are now closed. There were no new findings identified during this audit. A rating of continuous improvement was allocated for the success achieved in reducing resident falls.

## 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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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. A complaints register is maintained and there was evidence that complaints are acknowledged, investigated and resolved promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current.

The appointment, orientation and management of staff are based on good employment practice. A systematic approach to identify and deliver ongoing training to staff supports safe service delivery. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents of Kimihia Home and Hospital have their needs assessed by the multidisciplinary team on admission and within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised and based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is overseen by a diversional therapist and an entertainment officer. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness and no structural changes to the facility have occurred since the previous 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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. On the days of audit there was one resident using bedrails voluntarily (enabler) and eight residents who required bedrails or fall out chairs as restraints, to keep them safe from harm.

## 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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Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	1	38	0	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 complaints policy and associated forms comply with Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to raise concerns or complaints.</p> <p>The complaints register and associated documents reviewed showed that the four complaints received since the previous audits were fully investigated, and actions were taken through to an agreed resolution within acceptable timeframes. The Facility Manger (FM) is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints to the DHB or Office or the Health and Disability Commission.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their relative's status, and that they were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported by the records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff interviewed knew how to access</p>



		interpreter services.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic plan outlines the purpose, values, scope, and direction of the service provider. The document describes annual and longer term objectives and links to associated operational plans. Interview with the FM confirmed that business goals and other operational matters are discussed at monthly board meetings.</p> <p>The FM is an RN with relevant qualifications. This person has been in the role for two and a half years and has long term experience employed as an RN in aged care facilities. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through regular meetings with other facility managers in the Community Trust Care Association (CTCA) group. CTCA is part of a business entity comprising nine aged care facilities who share common factors, such as being located rurally and governed by not for profit organisations. Membership with CTCA continues to add value and business improvements to the service operations though cost savings and to resident care, via the liaison that occurs between employees (for example activities, managers, carers and RNs) across the different facilities.</p> <p>The service holds agreements with the DHB for age related care (ARCC) in rest home, dementia, hospital medical and geriatric care, respite and palliative care, Long Term Support-Chronic Health Conditions (LTS-CHC) and the Ministry of Health (MoH) for Young People with Disabilities (YPD)</p> <p>On the day of audit 63 of the 78 beds were occupied. Thirty three residents were receiving rest home level care (two of these were on short term respite and one person was under 65 years of age LTS-CHC). Nineteen residents were receiving hospital care and there were 12 residents in the secure unit.</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>	FA	<p>The organisation has an established quality and risk system that reflects the principles of continuous quality improvement. Their membership with CTCA includes shared policies and procedures and benchmarking between the nine facilities. The FM collates and analyses all incidents before submitting data for falls, urinary tract infections (UTI's) skin tears and pressures injuries for comparative benchmarking. Interview with the FM and review of 2019 staff meetings minutes confirmed that data for all incidents, infections and restraint is</p>

		<p>reported and discussed monthly. This provides evidence that the previous corrective action is now resolved.</p> <p>Other continuous quality activities are conducting regular resident and family satisfaction surveys and internal audits. The outcomes from these are reported to staff and the board. Where areas for improvement are identified these are documented and actions are monitored for implementation.</p> <p>Quality data and information is reported and discussed at monthly meetings of the health and safety committee, RN meetings (which always include review of infection control, and restraint matters) and general staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, training and information shared at meetings. The manager notifies all staff of corrective actions or policy/process changes by memos and verbally at meetings. Review of the most recent resident and family satisfaction surveys revealed no significant issues and moderate to high satisfaction.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>There is a current risk management plan which is monitored by the manager and the Board. The manager is familiar with the Health and Safety at Work Act (2015) and described processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies.</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>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed for 2019 revealed clear descriptions of the event, that the incidents were reviewed and investigated by the manager, and where necessary action plans developed. There was evidence that actions are monitored for implementation. Adverse event data is collated, analysed and reported to staff. Falls, urinary tract infections, skin tears and hospital admissions are benchmarked with the eight other facilities who belong to CTCA. Review of the comparative data showed a significant reduction in falls from 2018 to 2019, this area is rated as continuous improvement in criterion 1.2.4.3.</p>

		The manager reported there have been no notifications to the Ministry of Health or the DHB and public health as per the Section 31 reporting requirements. There have been no significant events such as outbreaks, police investigations, coroner's inquests, or issues-based audits.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of five staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation followed by an initial performance review.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Records reviewed demonstrated that 14 of the 40 care givers have completed level 4 of the National Certificate in Health and Wellbeing (or its equivalent) and 12 have achieved either level 2 or level 3. Each of the staff records reviewed contained evidence that a performance appraisal had occurred within the past year and that all new staff attend orientation. These previous areas of non-conformance are now closed.</p> <p>Six of the ten RNs employed are maintaining annual competency requirements to undertake interRAI assessments. Two more RNs are engaged in achieving interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed.</p>

		<p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, for the number of residents and their needs. The only staff rostered to work in the dementia care area have either completed, or are enrolled to achieve, the prerequisite unit standards in dementia care.</p> <p>The part time staff or agency personnel are used to replace staff unplanned absences.</p> <p>All RNs have a current first aid certificate including CPR and there is always an RN on site.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted the date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is recorded on the electronic record. Minimal use of PRN medication is sighted in the residents reviewed in the secure</p>

		<p>unit.</p> <p>There were two residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and one of the two clinical nurse managers (CNM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are used and meet guidelines.</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>FA</p>	<p>The food service at Kimihia is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in August 2018. Recommendations made at that time have been implemented.</p> <p>There is a food control plan in place and a verification audit of the plan was undertaken in August 2019. No corrective actions were required and the plan was approved for eighteen months.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The monitoring of the resident's individual fridge temperatures occurs weekly. Records verify temperatures are within the required range. Documentation evidences compliance the cleaning regime is being followed. This addresses a previous corrective action request. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Residents in the secure unit have access to food at any time day or night.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of</p>

		dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents of Kimihia was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</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>	FA	<p>The activities programme is provided by a diversional therapist and an entertainment officer.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. An individualised twenty-four-hour activities plan is in place for residents in the secure unit. Each resident's activity needs are evaluated regularly and as part of the formal three/six monthly care plan review.</p> <p>The planned monthly activities programme was sighted and matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included exercise sessions, seated yoga, music therapy, visiting entertainers, quiz sessions, crafts, daily 'happy hour' sessions and daily news updates. The activities programme runs six days a week with church services held on Sundays. The programme is discussed at residents' meetings and minutes indicate residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short-term care plans being instigated for infections, pain and weight loss. Progress is evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current Building Warrant of Fitness (BWOFF) due to expire on 13 March 2020.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>One of the two CNMs is the infection control nurse (ICN) and reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint register is being maintained and confirmed to be current and accurate on the day of audit. There were seven hospital residents and one rest home resident using bedrails for safety reasons and/or to promote independent mobilisation and two residents requiring placement in fall out chairs when seated. The service applies the same assessment, consent, monitoring and review processes for all safety interventions whether they are voluntary or not. Staff interviewed understood the differences between the voluntary use of enablers and use of restraint. A sample of residents' records and observations confirmed that restraint documentation and the processes for implementing and monitoring the safe use of restraint complies with this standard.</p>



## Specific results for criterion where corrective actions are required

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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.

No data to display
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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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	CI	<p>The average number of resident falls in the first half of 2018 was 25 per month. The FM and RNs introduced a range of new initiatives to prevent falls. These included implementing unique falls prevention plans for high risk (of falls) residents and evaluating these at monthly paper rounds with the physiotherapist, CNMs and specialist RNs.</p>	<p>A planned and evaluated project to reduce resident falls has resulted in more than halving the number of falls from an average 25 per month to 10 per month across the facility. There was only one admission to hospital subsequent to a fall in the first half of 2019 compared to nine admissions for the same period in 2018. There were no reported falls of hospital residents in July.</p>

End of the report.