

Dutch Village Trust - Ons Dorp Care Centre

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:	Dutch Village Trust
Premises audited:	Ons Dorp Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 September 2019 End date: 2 September 2019
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:	45

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
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

Ons Dorp Care Centre provides rest home, respite and hospital level care for up to 45 residents. On the day of the audit there were 45 residents residing at the facility.

This surveillance audit was conducted against the relevant Health and Disability Services Standards and the provider's contract with the DHB. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with family, residents, management, and general practitioner and clinical and non-clinical staff.

There are three areas identified as requiring improvement at this surveillance audit relating to complaints management, human resource management and interRAI and care plan assessment timeframes.

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.	Yellow	Some standards applicable to this service partially attained and of low risk.
--	--------	---

Staff, family and residents are informed of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights, the complaints process and the Nationwide Health and Disability Advocacy Service. Open disclosure between staff, residents and families is promoted and confirmed to be effective. There is access to interpreting services if required.

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.
---	--	---

Ons Dorp Care Centre is governed by a general manager who is responsible for the Village and oversees the care centre. The general manager is supported by the clinical manager. Both are newly appointed to their roles by the Trust Board.

Quality and risk performance are monitored and reported to the Trust Board. The facility has an incident and accident management system that records and reports all adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting. Documentation and interviews confirmed that staff communicate with residents and family members about incidents.

There are human resource policies in place and include recruitment, selection and appointment of appropriate staff. Orientation and regular training and education is provided. Staff competencies across a range of skills are also assessed routinely. Staffing is rostered to meet the numbers of residents in the facility and acuity levels. Staff, residents and family confirmed that staffing levels are adequate, and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

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.
--	--	---

Residents receive services in a competent and timely manner. The registered nurses (RNs) are responsible for completing nursing assessments, care plans and evaluations. Interventions are adequate to meet the residents' assessed needs.

The planned activities provided are appropriate to meet the needs, age, culture, and setting of the service. The activities reflect the ordinary patterns of life and include involvement of residents and/or representatives and other community groups.

The service uses an electronic medication system for e-prescribing and administration systems. Medication is administered by staff with current medication administration competencies. Medication reviews are completed by the general practitioners (GPs) in a timely manner.

All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. There is a current food control plan in place.

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 building warrant of fitness. There has been one external (courtyard) building modification since the previous audit. Resident rooms, the lounge and bathrooms have been renovated to a high standard. The resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

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.
---	--	--

Restraint minimisation processes are in place and the RN is the restraint coordinator. There was one resident using restraint and seven using enablers at the time of the audit. The restraint policy outlines that the use of enablers shall be voluntary with the intention of promoting residents' independence and safety. There are implemented policies and procedures that support the minimisation of restraint. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

Infection surveillance is undertaken, analysed and trended. Results are reported to the manager. Surveillance records showed evidence of follow-up of infection when required.

The infection surveillance programme is reviewed annually. Staff demonstrated current knowledge and practice in relation to the implementation of infection prevention and control.

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	13	0	3	0	0	0
Criteria	0	38	0	3	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The organisation's complaints policy and procedures were in line with the Code and includes timeframes for responding to a complaint. The clinical manager is responsible for all complaints, investigations and correspondence with the complainant. All documentation is in a file in the clinical manager's office and these were reviewed. Records were able to be followed through, but the complaints register reviewed had not been documented and maintained since August 2017. There were two complaints recorded in 2018 and nine written complaints have been received since January 2019. All are closed out on the complaint's forms sighted except for one complaint received 26 August 2019 which has also been sent to the DHB by the complainant. An area of improvement has been identified in relation to the complaints register.</p> <p>Information on how to make a complaint is made available at entry to the service as stated by residents and their families interviewed. All residents and the families interviewed state they know how to make a complaint if they needed to.</p> <p>There have been two Health and Disability Commissioner external complaints since the previous audit that have been closed out. There is one complaint that is open (as above) which has been sent recently to the DHB.</p>
Standard 1.1.9: Communication	FA	Residents interviewed stated that they are able to communicate easily with staff and feel free to raise any issues if needed. There is an open disclosure and interpreter policies and procedures in place. Family interviewed said they

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>are satisfied with the level of communication they had with the service.</p> <p>All staff interviewed are aware of the need for open and honest communication with residents and their families and are aware of how to access interpreters if required. The DHB interpreter service can be accessed if needed and staff are also able to assist if needed. Most residents at this facility speak Dutch and there are staff who are able to translate as necessary. Residents of other nationalities are also well represented by staff of the same cultures.</p> <p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family of any issues or change in condition that occurred in consultation with the resident. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family were informed if the resident had an incident, accident or a change in health status and this was evidenced in the completed accident/incident forms reviewed. Interview with family members confirmed they were kept informed.</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>The organisation has a strategic plan dated 2016 to 2019 which identified the organisation's mission statement, vision and philosophy and shows the organisation's planning process to meet the residents' needs. Meetings for the care centre are held monthly with the trust board to determine if the objectives set meet the needs of the residents. This is reflected in the goals sighted which cover all aspects of service delivery. The business planning includes an assessment of the strengths and weakness of the service for this charitable trust.</p> <p>The service is managed by a general village manager who oversees the care facility and village (seven months in this role) and the clinical manager (six months in this role) who is responsible for the care facility. The staff and residents report to the clinical manager and stated the clinical manager is approachable and addresses any concerns they may have. Both the general manager and the clinical manager report directly to the trust board.</p> <p>The service holds contracts with the DHB for rest home, respite care and hospital level care (geriatric and medical). The service has 44 dual purpose beds and one respite care bed. On the day of the audit the total occupied beds were 45 which included 25 hospital level care residents and 19 rest home level care residents and one respite care resident.</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>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and accidents, complaints, audit activities, a regular resident annual satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint minimisation and safe practice.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and staff meetings. Staff interviewed reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. The clinical manager interviewed is reviewing the audit schedule to evidence more</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>appropriate timeframes between audits undertaken. A survey was completed of residents/family and staff in May this year. Positive feedback was received.</p> <p>The policies and procedures reviewed cover all contractual and service obligations including reference to the interRAI long term care facility (LTCF) assessment tool and process. Policies are based on best practice and are regularly reviewed and reference the relevant sources, approval and distribution. Obsolete documents are removed and stored appropriately for the required timeframe before being destroyed.</p> <p>The clinical manager interviewed is fully informed about the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The staff interviewed understood that they had to complete an incident form for any adverse or near miss events. A sample of forms was sighted and evidenced that the forms were completed, incidents were followed up by the clinical manager and action plans developed and followed through in a timely manner. All adverse events data is collated, analysed and reported to the quality and staff meetings. Minutes of the meetings were reviewed. Any outcomes or issues were reported by the clinical manager at the trust board meetings held monthly. Unwitnessed falls protocol is known to staff interviewed and neurological observations are used as per the policy reviewed. Family members are notified, and this is recorded on the incident form, in the progress records and the family communication record in each resident record reviewed.</p> <p>The clinical manager described essential notification reporting requirements, including any pressure injuries. One section 31 notice has been sent to the MoH in relation to when staffing numbers were not at the required level since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of</p>	<p>PA Low</p>	<p>Human resource management policies and processes are based on good employment practice and relevant legislation. A sample of staff records were reviewed and included refer checks, policies vetting and validation of allied health professionals' qualifications and that of the GPs, registered nurses and the contracted pharmacy and pharmacists annual practising certificates (APCs) where required. The records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The records are filed in the clinical manager's office in a locked filing cabinet.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for the roles they play in the organisation. The staff records reviewed evidenced completed orientation for infection control, restraint minimisation and other topics. In addition, ongoing competencies for HCAs and RNs as required are completed. Cleaning and laundry staff have completed relevant training on products utilised in those services. Most staff have completed a first aid and the certificates were observed in the records</p>

legislation.		<p>reviewed. An area of improvement was identified in relation to the performance appraisals not being currently up to date.</p> <p>Education is planned on a two-yearly basis, including mandatory training requirements. The health care assistants have either completed or commenced a New Zealand qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. There are two registered nurses who are workplace assessors. All health care assistants have completed level 4 NZQA equivalent training. Education records and certificates were present in the staff records reviewed. There are six registered nurses plus the clinical manager employed in this service currently. Advertising is ongoing to increase the number of registered nurses needed. There are three registered nurses including the clinical manager who are competent to complete the interRAI assessments. One registered nurse is completing the training course currently.</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 system in place for determining staffing levels and ensuring skill mixes are appropriate to cover the service 24 hours a day, seven days a week (24/7). The clinical manager adjusts the staffing levels to meet the acuity levels and changing needs of residents. The clinical manager covers the after-hours. The healthcare assistants interviewed stated there were adequate staff available and that teamwork is encouraged. On visual inspection and review of a four-week roster cycle confirmed adequate staff cover is provided. Staff are replaced for study leave, sickness or annual leave or any other unplanned absence. Registered nurses are on duty every shift and there is always one staff member on duty who has a current first aid certificate.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>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. The RN completes medication reconciliation when packs are received from the pharmacy. 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 and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries were sighted.</p>

		<p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Short course, discontinued medicines and all requirements for pro re nata (PRN) medicines were met. The required three-monthly GP review was consistently recorded on the electronic records sighted.</p> <p>There was one resident 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>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by an external contractor and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter cycles and has been reviewed by a qualified dietitian and a nutritionist within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The food service operates with an approved food control plan. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have completed safe food handling qualification, and kitchen assistants have completing relevant food handling training.</p> <p>A nutritional assessment is completed 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. Interviewed residents and family reported that food alternatives provided per request. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>Interviewed residents and family reported satisfaction with the food provided. Satisfaction surveys and resident meeting minutes were sighted.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Care provided to residents was consistent with their assessed needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is provided as required. 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>	<p>FA</p>	<p>The activities programme is provided by the activities team. The activities coordinator is responsible for completing the activities assessment for all residents on admission with input from the residents or family where appropriate. A social assessment and history are completed on admission to ascertain residents' needs, interests, abilities and social requirements. Individual activities plans were sighted in files reviewed. There is a monthly and weekly activities programme. The weekly activities programme is posted on the notice board and given to individual residents. There are group activities and individual activities. There are activities planned for rest home level residents and separate for hospital level residents. However, residents who want to attend to either activities are allowed to do so freely. There are also combined activities planned for external entertainers. Residents have access to community events and community outings. Residents were observed participating in various activities on the day of the audit.</p> <p>Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. An activity participating register is completed daily by the activities team. The resident's activity needs are evaluated as part of the formal six-monthly care plan review with input from the activities team.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Interviewed residents reported satisfaction with the activities programme.</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 by the healthcare assistants (HCAs). Any change noted, is reported to the RNs. The RNs documents in the progress notes at least weekly. There is a process for evaluating the long-term care plans and interRAI assessments six-monthly, however this was not met consistently (refer 1.3.3.3).</p> <p>Where resident's progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were being consistently reviewed and progress evaluated as clinically indicated. Residents and families/whānau interviewed confirmed their 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</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed in the reception office and expires 23 November 2019. A monthly safety inspection is recorded, this records environmental inspections, inspection of furnishings and equipment and review of the civil defence supplies. The electrical equipment evidenced current test and tag inspection labels, appropriate to the type of equipment and environment. Annual calibration of the medical equipment was last conducted May 2019.</p> <p>There has been a total upgrade of the external courtyard area which is covered in and can be used all year and all seasons. There is appropriate garden furniture with comfortable seating and planters for the setting. Renovations to residents' rooms and all bathrooms have been completed. New carpet throughout the facility was evident and</p>

their purpose.		<p>furnishings and wall paintings have been replaced.</p> <p>The residents and families reported satisfaction with the environment at Ons Dorp Care Centre.</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>	FA	<p>Surveillance for infections is carried out in accordance with agreed objectives, priorities and the methodology that is specified in the infection control programme. The surveillance programme reviewed is appropriate for this care centre. Surveillance forms have been developed and implemented for the reporting of infections. Information gained is reported as part of the quality management system requirements and quality improvement objectives on a monthly basis and quarterly overview/analysis. Any immediate trends are reported to staff to implement actions. The infection data evidences minimal numbers of infections, where there has been any increase, such as an increase in urinary infections actions are implemented to reduce the reoccurrence.</p> <p>Staff report that they are kept well informed and understood their responsibilities for reporting any signs and symptoms of a resident having an infection.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and responsibilities.</p> <p>On the day of audit, one resident was using restraint and seven residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	The previous complaints records were maintained and were up to date up to date in the complaints register until August 2017. The complaints register is the responsibility of the clinical manager. Records were kept in a folder in the clinical manager’s office, but not filed appropriately to meet the requirements of the Code in the complaints register.	Complaints have been addressed but the complaints register reviewed has not been maintained since July 2017.	<p>To ensure the complaints register is maintained to include all complaints, dates and actions taken.</p> <p>180 days</p>

<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>The staff interviewed were skilled and/or had completed relevant training and education to safely meet the needs of the residents. The clinical manager did not have a schedule to evidence staff have annual performance reviews. The eight staff records reviewed did not evidence that annual staff performance reviews had been completed</p>	<p>The staff annual performance appraisals have not been completed in a timely manner.</p>	<p>To ensure staff appraisals are completed annually as per policy reviewed.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	<p>PA Low</p>	<p>Registered nurses are responsible for all assessment, care planning and evaluation. Each resident's lifestyle care plan details strategies to maintain and promote the resident's independence, wellbeing and, where appropriate, their community involvement. Short term care plans were completed for acute conditions, evaluated in a timely manner and closed off when the acute conditions resolved. There are trained RNs who are responsible for completing interRAI assessments and one RN is still undergoing interRAI training. An improvement is required to ensure that interRAI assessments and care plans are completed in a timely manner.</p>	<p>Residents' records reviewed evidenced that interRAI assessments and lifestyle care plan evaluations were not completed within three weeks of admission and evaluated six monthly.</p>	<p>Ensure interRAI assessments and lifestyle care plan evaluations are completed in a timely manner.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.