

Prasad Family Foundation Limited - Brylyn Residential Care

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 BSI Group New Zealand Ltd, 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: Prasad Family Foundation Limited

Premises audited: Brylyn Residential Care

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 19 October 2020 End date: 20 October 2020

Proposed changes to current services (if any): There were three studio units that had married couples. These three studio units were verified as part of this audit as suitable to be used as double rooms. This will increase overall beds numbers to 35 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 31



Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Brylyn Residential Care is owned and operated by the Prasad Family Foundation Limited. The service provides cares for up to 32 residents requiring hospital and/or rest home level care. On the day of the audit, there were 31 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, the general practitioner, and management.

The nurse manager has previous experience in aged care and is supported by registered nurses. Residents and relatives interviewed were very complimentary of the services and care they receive.

The service has addressed two of the four shortfalls identified at the previous certification audit around implementation of new policies and calibration of equipment. There continues to be an improvement required around timeframes relating to documentation of assessments and care plans interventions.

This surveillance audit identified areas for improvement around the business and quality/risk management plan; to clarification of numbers of residents able to be accommodated in the service; the quality improvement programme; completion of neurological observations when required; comprehensive documentation of evaluations; and to a strong smell in parts of the facility.

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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Residents and relatives are kept up to date when changes occur or when an incident occurs. A complaints policy is documented, and a complaints register maintained. There have not been any complaints since 2017.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a business and quality plan documented. This defines the scope, direction and objectives of the service and the monitoring and reporting processes.

The nurse manager provides leadership with registered nurses on site taking a lead in day-to-day clinical care.

There is a documented quality and risk management system in place. Policies, procedures, and forms are in use to guide practice with these now rolled out to staff. Quality outcomes data is collected. Adverse events are documented.

The human resource management system is documented in policy, with recruitment completed as per policy. There is an orientation programme and annual training plan that is implemented. Staff have annual performance appraisals.

There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery in the rest home and hospital. An appropriate number of skilled and experienced staff are allocated to each shift.

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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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and plans residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans demonstrated service integration and resident/relative input into care.

An activities coordinator oversees the activity team and coordinates the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and preferences for each resident group. Residents and relatives reported satisfaction with the activities programme.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for the administration of medicines and complete annual education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three-monthly.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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.		Some standards applicable to this service partially attained and of low risk.
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The building holds a current warrant of fitness. Residents can freely mobilise or be transported safely within the communal areas. There is safe access to the outdoors, seating, and shade.

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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Brylyn Residential Care has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents using restraint or enablers.

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 control policies are documented. A registered nurse is the infection control coordinator, and they ensure that surveillance of infections is documented, data discussed, and strategies put in place to improve lives of residents. The organisation has a low rate of infections.

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	11	0	2	4	0	0
Criteria	0	35	0	4	4	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 service has a complaints policy that describes the management of complaints process. There is a complaint form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed (nurse manager; four HCAs including two who work predominantly afternoon shift and two on the morning shift; two [one from the morning shift and one from the afternoon shift]; one cook, one activities coordinator who is also the residential care officer, and one cleaner) could describe the process around reporting complaints.</p> <p>There is a complaint register. There have been no complaints since 2017. The nurse manager confirmed that complaints would be documented. There have been no complaints since the last audit from external providers (eg, district health board or Health and Disability Commissioner).</p> <p>Discussions with residents confirmed that any issues are addressed, and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Residents (four from the hospital and three rest home) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs.</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Twelve incidents/accidents forms were reviewed for September 2020. All had confirmation of family being informed. Relatives (one with family in the hospital and one in the rest home) interviewed confirmed that they are notified of any changes in their family member's health status.</p> <p>There is communications with family noted in the resident record and this confirms any communication with family or others.</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>Brylyn Residential Care currently provides care for up to 32 residents.</p> <p>All beds are dual purpose rooms with the service only able to have up to ten residents requiring hospital level of care at any given time. Currently there are three couples occupying three of the studio units. These three studio units were verified as part of this audit as suitable to be used as double rooms. This will increase overall beds numbers to 35 beds.</p> <p>At the time of the audit, there were 31 residents including 21 requiring rest home level of care (three identified as being under a young person with a disability contract) and 10 requiring hospital level of care (one identified as being under a young person with a disability contract).</p> <p>Brylyn Residential Care is privately owned with two directors who communicate with the nurse manager on a weekly/monthly basis. A business plan and a quality and risk management plan are in place. The business plan and quality/risk management plans have not been reviewed, although they do include the scope, direction, and goals of the service.</p> <p>The nurse manager is a registered nurse with a current practising certificate. They have been in role since late 2018. The nurse manager has over 10 years' experience in aged care and has also held unit manager roles at a previous organisation. The nurse manager has over eight hours of professional development per year with management training completed (Basics for Business). The nurse manager is supported by registered nurses in the service.</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>PA Moderate</p>	<p>Brylyn Residential Care has a documented quality management system. There are documented policies and procedures to guide staff. Staff have access to the current manuals. The service has purchased policies and procedures from an external provider, and these have been rolled out for staff. The previous corrective action identified at the certification audit related to review of policies has been addressed. There is a formalised document control programme in place.</p> <p>The nurse manager (registered nurse) is responsible for implementation of the quality and risk management programme. An internal audit schedule is in place; however, audits have not been completed since 2019. Data is collected for falls, skin tears, medication errors, incidents and accidents, restraint use, and infections. This</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>information is collated and analysed with documentation of corrective action plans for some issues when these arise (eg, incidents, accidents, and infections monthly). Evidence of resolution of issues is not documented.</p> <p>Staff meetings are held; however, there is a lack of evidence of discussion of quality data. Clinical meetings are held informally for the registered nurses. There are management meetings held monthly.</p> <p>There are annual resident and family satisfaction surveys. The last survey in 2019 showed satisfaction with the service, however there were a number of opportunities for improvement raised. A corrective action plan has not been documented.</p> <p>A health and safety system is in place. Hazard identification forms and a hazard register are in place. Maintenance is addressed as issues are identified. The nurse manager and staff are aware of and able to describe their responsibilities to health and safety. Health and safety is covered at orientation for new staff, with staff also having ongoing training annually around health and safety. The health and safety representative has attended training on Health, Safety and Accident Investigation and when interviewed, was aware of their role.</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 accidents and incidents reporting policy. The nurse manager investigates accidents and near misses. There is documented evidence to reflect accident and incident information is being communicated to staff through the staff meetings.</p> <p>A registered nurse conducts clinical follow-up of residents and clinical assessments following unwitnessed falls are fully documented. Incident forms for residents who had a head injury or unwitnessed fall did not always confirm that neurological observations were completed as per policy (link 1.3.6.1).</p> <p>Discussions with the nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The nurse manager stated that there have not been any issues that have required notification to an external authority.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices, orientation and staff training and development. The orientation programme provides new staff with relevant information for safe work practice. A review of staff files confirmed that staff have completed the organisational orientation programme. Two new staff interviewed stated that they had a full orientation to the service with this including reading of policies, introductions to staff and residents and buddying with another staff member for a week. Both stated that they could ask other staff or the registered nurses for any further advice or support at any time.</p> <p>Five staff files were reviewed (one nurse manager, two registered nurses, one healthcare assistant, and cook).</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>All files showed records of recruitment with reference checks and a signed contract on file.</p> <p>Current practising certificates were sighted for the registered health professionals as well as for the other health professionals who provide support for residents in the service. These included the doctors, pharmacist, and dietitian.</p> <p>There was a documented education plan for 2020 with this having been fully implemented. Toolbox talks at handover are recorded with an attendance record kept. Staff appreciate these as a way to address any current issues and to constantly improve practice. Four registered nurses and the nurse manager are able to complete interRAI assessments.</p> <p>The nurse manager and the registered nurses can attend external training, including sessions provided by the local DHB.</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>There is a documented staffing policy and there is a registered nurse rostered on each shift. The nurse manager is able to provide support if required.</p> <p>For 31 residents (21 rest home and 10 hospital level of care). There is at least one registered nurse on each shift, two healthcare assistants (HCAs) on the morning shift along with a residential care officer or three HCAs; two HCAs on the afternoon shift and one healthcare assistant overnight.</p> <p>Staff stated that there are sufficient staff for the number and acuity of residents. This was confirmed by the nurse manager with observations of the service confirming that there were sufficient staff in the morning and afternoon for resident needs to be met. All confirmed that staffing levels were increased in response to a change in acuity or resident need.</p> <p>There are 22 staff employed in the service including the nurse manager, an activities coordinator, five registered nurses, and nine healthcare assistants. Household staff are employed with healthcare assistants completing laundry tasks. The rosters reviewed confirmed that staff are replaced when on leave.</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</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislation and guidelines. All registered nurses and healthcare assistants who administer medications have an up-to-date annual medication competency on file. An electronic medication system is utilised. Medications are delivered in robotics packs from the pharmacy and all medications are stored safely in the treatment room. Medications are checked against the medication chart on arrival. Standing orders are not used. Processes are in place for the safe management of self-medicating residents. There were no residents self-medicating on the day of audit. Medication fridge and room temperatures were documented as checked daily.</p> <p>All ten medication charts reviewed (four hospital and six rest home) had photo identification and allergy status</p>

guidelines.		identified. The GP has reviewed the medication charts three monthly. 'As required' (PRN) medication had indications documented. The effectiveness of PRN medication was documented.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals and baking are prepared and cooked on site by a chef. The chef works eight and a half hours per day five days a week. Two days are covered by a relief cook. The chef interviewed, stated they had attended the last resident and family meeting. There is a four-week seasonal menu in place which has been reviewed by a dietitian. There is a current food control plan which is expiring July 2021. Meals are served directly from the kitchen to residents in the dining room. Dietary needs are known with individual likes and dislikes accommodated and documented on a board in kitchen. Dietary requirements, cultural and religious food preferences are met. Additional or modified foods are also provided by the service. Fridge, freezer and end cooked temperatures are monitored and recorded daily. A kitchen cleaning schedule is in place and implemented. Residents interviewed, stated overall, the meals provided were good.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	The resident's long-term care plans reviewed were resident focused. However, not all care plans included interventions to support all resident current assessed needs. The previous audit shortfall continues to be an area requiring improvement. Acute care plans were used for short-term needs. Nursing care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. Behaviour monitoring charts are in place for residents with challenging behaviour. Evidence is present of family members being notified of any changes to their relative's health status, incidents, and updates. Discussions with families and notifications were documented on the family/whānau contact sheet in the resident files. Adequate dressing supplies were sighted in the treatment room. The wound care file was reviewed. Wound assessments, treatment and evaluations were in place for all current wounds (one skin tear and one resident with three wounds). There were no pressure injuries on the day of audit. The RNs interviewed were able to describe the referral process for a wound care nurse specialist if required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Staff interviewed stated that they have enough stock available and are aware of how to access stock if need arises. Sufficient gloves and aprons were available and sighted for

		<p>staff to utilise.</p> <p>Residents are weighed monthly or weekly for those that have weight loss. Nutritional requirements and assessments are completed on admission (link 1.3.3.3.and 1.3.5.2).</p> <p>Acute care plans document interventions to manage short-term changes in health. Staff interviewed were aware of residents needs and understood interventions on how to meet them.</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>An activities coordinator (residential care officer) implements the activities programme from 9 am to 2 pm, Monday to Friday. They have been in the service for five years and in the role for three years and have a Diploma in Healthcare, level five. An integrated activities programme is documented for the year and provided for rest home and hospital residents with group and individual activities. Residents have a copy of the activities plan and this is displayed in the facility.</p> <p>The majority of the activities are held in the main lounge. There is a variety of activities that meets the abilities of all residents including (but not limited to) daily exercises to music, board games, gardening, crafts, and newspaper reading. On Saturday mornings there is a music session and happy hour run by community entertainers. Three one-on-one sessions per week are dedicated to residents who choose not to join in group activities or are unable to participate in activities. Interdenominational church services are held on site fortnightly. Families are invited and welcome to become involved in the activity programme. The service hires rental vans with wheelchair access for outings into the community once a fortnight. An external hairdressing service comes to the facility once a fortnight. Residents and family interviewed expressed satisfaction with the activities programme. During the audit, residents and family were observed to engage in activities.</p> <p>An activity assessment and plan are completed on admission in consultation with the resident/family (as appropriate) and reviewed six-monthly (link 1.3.5.2).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Long-term care plans have not all been completed within 21 days. There is documented evidence that care plan evaluations are completed, however these have not always been completed following the interRAI reassessment six-monthly (link 1.3.3.3).</p> <p>The registered nurse completes an evaluation at three monthly intervals; however, this is not an evaluation of the care plan including all domains in the care plan. Care plans have been updated as changes occur.</p> <p>The GP reviews the residents at least three monthly or earlier if required. The multidisciplinary review team includes the RN/primary nurse, nurse manager, healthcare assistants and the resident/relative and any other allied health professional involved in the care of the resident.</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>PA Low</p>	<p>The building has a current building warrant of fitness that expires 20 September 2021.</p> <p>There were three studio units that had married couples. These three studio units were verified as part of this audit as suitable to be used as double rooms. The three rooms had enough space for mobility equipment and had two call bells in place.</p> <p>The service employs a part-time maintenance person that works six hours per day. A maintenance logbook (sighted) is completed for maintenance requests and signed-off as addressed. Planned maintenance includes interior and exterior maintenance. An inventory book is being commenced on equipment within facility. The two hoists and chair scale have been calibrated annually. All medical equipment has been calibrated annually and the recommendation identified at the previous certification audit has been addressed. Electrical equipment had been tested and tagged. Essential contractors are available 24 hours as required. Hot water temperature monitoring is randomly checked in resident rooms and communal facilities every month and documented. Temperatures in resident areas are maintained less than 45 degrees Celsius.</p> <p>The facility corridors have wide enough space for residents to safely mobilise using mobility aids or in lazy boy chairs, with the assistance of staff. There is a strong smell of urine in some areas.</p> <p>There is safe access to the outdoor areas with rails and ramps in place. Seating and shade are provided. The lawn and gardens were well maintained and clean.</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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (registered nurse who has been in the service of a year) collates infection control events monthly and the data is analysed for trends and opportunities for improvement and training opportunities. Individual infection reports, and acute care plans are completed for all infections as sighted in resident files reviewed. This included for example, clear documentation of urinary tract infections with documentation in monthly data confirming what occurred for the resident as per the resident file.</p> <p>Definitions of infections are in place, appropriate to the complexity of service provided. There is documented evidence of trending, analysis, or discussion around infection control data at staff meetings.</p> <p>There have not been any outbreaks since the last audit. All Covid-19 precautions have been fully implemented with sufficient PPE in place for at least two weeks should that be required. Staff have had frequent training and updates around the pandemic since March 2020.</p>
<p>Standard 2.1.1:</p>	<p>FA</p>	<p>There are restraint minimisation and safe practice policies and procedures applicable to the size and type of the</p>

<p>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>service. The restraint policy includes a definition of enablers and procedures for assessment and appropriate use of enablers (that is, voluntary restraint). There were no enablers or restraints in use during the audit. The restraint coordinator is a senior nurse who has been with the service for over a year. Staff have training at least annually around managing challenging behaviour.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	The business plan and quality/risk management plans are documented. These have not been reviewed for 2019 or 2020.	The business plan and quality/risk management plans have not been reviewed at frequent intervals and annually prior to the new plans being developed.	Ensure the business plan and quality/risk management are reviewed at frequent intervals and annually prior to the new plans being developed. 180 days
Criterion 1.2.3.6 Quality improvement data are collected,	PA Moderate	Data is collected from infections, key indicators (eg, falls and medication errors and incidents/accidents). There is documentation of analysis on the data collection forms and some corrective actions documented. There	(i). There is only some documentation of discussion of trends and corrective actions in the meeting minutes. (ii). Resolution of issues is not documented. (iii). The audit schedule has not been implemented in	(i).Ensure meeting minutes reflect discussion of trends and corrective actions.

analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.		is some evidence of discussion around the data in meeting minutes. Evidence of resolution of issues is not documented. An audit schedule is documented. The last audits were completed in February 2019.	most of 2019 and 2020.	(ii). Ensure that issues are resolved with resolution documented. (iii). Ensure the audit schedule is implemented. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	The satisfaction survey completed in November 2019 has a number of opportunities for improvement identified. An action plan has not been documented.	A corrective action plan has not been documented for the resident/family satisfaction survey completed in 2019.	Document a corrective action plan for the resident/family satisfaction survey completed in 2019 and implement with evidence of resolution of issues. 180 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that	PA Moderate	The initial assessment and care plans in four of five resident files reviewed had been dated and confirmed that all had been completed on the day of admission. Two resident records at rest home level of care showed that the first interRAI had been completed within 21 days. The interRAI assessments have been completed six-monthly when this was required in three of four files reviewed. One of the long-term files reviewed confirmed that	(i) The initial assessment and care plan in one of the resident files reviewed was not dated. (ii) Three resident records at hospital level of care showed that the first interRAI had not been completed within 21 days. (iii) In four of the long-term files reviewed (two hospital and two rest home level of care including two who had been admitted in 2020), the long-term care plan had not been developed within 21 days following admission. (iv) The interRAI assessments have not been completed six-monthly in one of four files reviewed. (v) The long-term plan was not reviewed in a timely manner after the	(i) Ensure that initial assessments and care plans are dated and completed in a timely manner. (ii) Complete the first interRAI within 21 days following admission. (iii) Ensure that the

safely meet the needs of the consumer.		<p>the interRAI assessments and care plans have been developed within 21 days of admission.</p> <p>The long-term plan was not reviewed in a timely manner after the interRAI had been completed (eg: in some instances the long term care plan was reviewed and updated before the interRAI had been documented or over a month after the interRAI had been completed). Care plan evaluations have not been completed in a timely manner.</p>	interRAI had been completed.	<p>initial long-term care plan is developed within 21 days following admission. (iv) Complete an interRAI re-assessment at six monthly intervals or earlier if health changes. (v) Ensure that the long-term plan is reviewed in a timely manner (i.e., after the interRAI has been completed).</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>The long-term care plans are developed in consultation with the resident/relative. Assessments are completed on admission including nutritional, continence, falls assessments, and interRAI assessments (link 1.3.3.3). Assessments assist in developing care plan interventions (link 1.3.3.3). The four long-term resident care plans reviewed did not include interventions to support all current assessed needs. The previous corrective action remains. Care staff interviewed could describe providing care as per the needs of the resident and the GP interviewed stated that the care</p>	<p>1. Four of the long-term care plans reviewed did not include interventions and needs/supports for the resident as identified through discussions with care staff and as identified through the assessment process. (i) There is one communal weight management plan documented for four residents with weight loss and this is only signed off by the HCA. The registered nurse interviewed stated that they look at the care plan as soon as it is completed (same day) however, while the registered nurse signs off weight management plans that have been documented by the HCA, there is no verification that these consider the interRAI assessments etc. A fluid and food balance chart was completed for the resident until early September 2020 with no documentation to confirm that this was to be discontinued. (ii) No interventions were documented in the care plan for a resident who had pain and few interventions were documented for a resident</p>	<p>1. Ensure care plans include interventions to support the resident's current needs.</p> <p>2. Ensure that activities assessments/plans are reviewed alongside the review of the care plan.</p>

		provided met the needs of residents. Activities assessments/plans were reviewed alongside the review of the care plan in two of the five resident files reviewed.	with falls and pain. (iii) A lack of interventions for a resident with mobility issues who required support to transfer with specific equipment used. 2. Activities assessments/plans were not reviewed alongside the review of the care plan in three of the five resident files reviewed.	90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Neurological observations are required to be taken when a resident has an unwitnessed fall or a fall with a head injury. These were not always completed as per policy.	Five of six incident forms for a resident with an unwitnessed fall or a fall with a head injury did not show that neurological observations are taken as per policy.	Ensure that neurological observations are taken as per policy for any resident who has an unwitnessed fall or a fall with a head injury. 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Evaluations are completed three-monthly by the registered nurse. There is not a comprehensive evaluation of all domains of the care plan in relevant resident files reviewed.	There is not a comprehensive evaluation of all domains of the care plan in four of four resident files reviewed who had been admitted for over six months.	Ensure that the care plan is fully evaluated at the six-monthly review of the care plan. 90 days

<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>The facility corridors have wide enough space for residents to safely mobilise using mobility aids or in lazy boy chairs, with the assistance of staff. There is a strong smell of urine in some areas.</p>	<p>There is a strong smell of urine in two of the hallways.</p>	<p>Address the strong smell of urine in two of the hallways.</p> <p>90 days</p>
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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.