

Bryant House Limited

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:

Legal entity: Bryant House Limited

Premises audited: Bryant House

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 29 January 2016 End date: 29 January 2016

Proposed changes to current services (if any): The service has converted a dayroom in the dementia unit to a bedroom, this now makes a configuration of a 17 bed dementia unit and 16 bed rest home.

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

Bryant House provides rest home and secure dementia care services for up to 33 residents. The layout of the service includes a 17 bed dementia unit (this has increased by one bedroom since the previous audit) and a 16 bed rest home. There were 31 residents at the time of audit.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included the review of documentation, observations and interviews. The audit report is an evaluation of the combined evidence on how the service meets each of the standards.

At the previous partial provisional audit, there was one area requiring improvement, to ensure the external areas to the dementia unit are completed. This was completed prior to the service commencing the use of the wing as a secure dementia unit.

There are two areas requiring improvement identified at this audit related to medicine management and documentation of care interventions.

Positive feedback was received from the families and residents regarding the quality of the care provided and the improvements that are being made to the environment.

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.

The service has processes in place to communicate openly with residents and families. If required the service can access interpreting services.

The complaints management system is easy for residents to access and use. There is a complaints register that contains any complaints and actions taken to address any concerns.

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.

Organisational structures and processes are monitored at organisational level. Service performance is aligned with the organisation's philosophy and goals identified in the business plan.

The service has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed by the management team annually and quality and risk performance is reported through meetings at the facility and monitored by the management team. Review of service delivery includes incidents/accidents, infections, complaints and reports from the internal audit programme.

The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Policies and procedures are documented to guide staff on all aspects of service delivery.

The manager is suitably qualified and is supported by a clinical manager. Resident and staff records reviewed were well documented and maintained by the clinical nurse manager and the manager.

Systems for human resources management are established and implemented. The education programme for all staff is available and planned for the year. The required training is provided for staff who work in the dementia unit.

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 medium or high risk and/or unattained and of low risk.
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A registered nurse is on site weekdays and available on call at all other times to provide support and guidance to the care giving staff. Verbal handovers at the start of each shift, written handover sheets, and the updating of residents' progress notes each shift, help promote continuity of residents' service delivery.

Care delivery meets the identified needs of residents and supports the achievement of their individualised goals. Assessments, care plans and evaluation of progress towards identified objectives are detailed, thorough and undertaken in a timely manner, although the development of care plans related to the management of behaviours of concern and also diabetes management are identified as areas requiring improvement. Residents are seen promptly by the doctor on their admission and reviewed regularly and additionally as clinically indicated.

All aspects of medication management comply with legislative requirements and best practice guidelines, with the exception of ensuring that all medications are within current use-by dates. Medications are administered only by registered nurses and caregivers who have completed medication competency assessments.

An experienced diversional therapist coordinates and oversees a varied activities programme. This includes regular outings in the facility's van, exercises, games and quizzes and entertainment.

Residents reported their enjoyment of meals. The organised and well-maintained kitchen accommodates a range of individual resident's food likes/dislikes and dietary needs. There are three separate dining areas for residents, who may also have their meals in their room if they wish.

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.

There is a current building warrant of fitness. Since the last audit the service has converted a day room in the dementia unit to a bedroom. This has not made any changes to the footprint of the service that has required changes to the approved evacuation scheme.

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.

There is no restraint or enabler use at the service. If enablers are to be used, it is clearly documented that these will be voluntary and the least restrictive option to maintain the resident's safety, comfort or independence. The layout of the dementia unit provides a safe environment for residents with cognitive impairment to wander freely.

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.

Surveillance of resident infections is appropriately managed for the size and complexity of the service. Well-established processes are in place for infection surveillance, and for reporting of and responding to surveillance results and sharing these with staff.

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	14	0	1	1	0	0
Criteria	0	38	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints process sighted identified the required procedures and complies with time frames within Right 10 of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Complaints management information is included in resident information packs and discussed with residents and their families as part of the admission process. Complaints forms are accessible to staff, residents and families. The residents and families report that if they have any issues or make a complaint, the issues are actioned 'almost immediately'. Staff confirmed their understanding of the complaints process.</p> <p>The complaints register contains the date the complaint is lodged, nature of the complaint, actions taken and the date resolved. One internal complaint from January 2016, in which the investigation and corrective action has been implemented, is awaiting final feedback from the complainant to confirm if they were satisfied with the outcomes of the actions implemented.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	The family/whānau members confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Two of the families of residents living in the dementia unit reported that communication is one of the strengths of the service. Evidence of open disclosure was documented in each resident's file, through the family communication sheet, on the accident/incident forms and in the residents' progress notes.

provide an environment conducive to effective communication.		All residents are able to communicate effectively in English. Staff demonstrated knowledge of how to contact an interpreting service if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The services are planned to meet the needs of the residents. The home consists of a 17 bed secure dementia unit and a 16 bed rest home. At the time of audit there were 17 residents living in the dementia unit and 14 residents living in the rest home. There is one rest home resident under the age of 65.</p> <p>Bryant House is a family owned and run business. The philosophy, vision and mission are documented in the business expansion plan for 2015/2016. The plan is reviewed on an annual basis and as changes to the estimated timelines for achieving goals occur. Objectives are documented for the rest home and dementia services related to facility improvements, planned maintenance and people. These include actions and budgeting related to the leadership programme, dementia training and the in-service education programme.</p> <p>One of the owner's has the 'hands on' role of the business manager. There is a clinical nurse manager who is a registered nurse (RN), who has the responsibility and authority for the clinical aspects of the service. The clinical nurse manager has been in the management role for the past two years and was previously a RN at the service. The clinical nurse manager has completed post graduate education related to dementia care and has attended the required education hours related to management of a care facility, as well as relevant clinical education on the needs and issues of the rest home and dementia unit. The clinical nurse manager is enrolled in a leadership course and has access to a clinical consultant as required. The business manager and clinical nurse manager are also supported by a quality improvement team (which includes another RN, kitchen manager, senior caregiver and a diversional therapist).</p> <p>The residents and families report satisfaction with the way in which individualised care and support is provided at Bryant House.</p>
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality	FA	<p>The quality and risk plan details the risks, current controls and ongoing actions required to provide safe and appropriate care. The quality and risk systems are monitored through internal audits, surveys and the quality improvement team meetings. Each of the quality goals identified covers all aspects of care and service delivery. Staff are actively involved in the quality programme and demonstrated an understanding of what the organisation aims to achieve. The outcomes of the internal auditing and quality management systems are discussed at the weekly debriefing sessions and staff meetings. Staff confirmed they understood and implement the quality and risk management systems. All potential and actual risks are reported at board level and reviewed regularly. Clinical risks are discussed at weekly debriefing sessions and staff meetings.</p> <p>The policies are developed by the clinical consultant. The organisation currently reviews all documents in a two yearly cycle, or more frequently if there is best practice or legislative changes. Recent changes include changes</p>

		<p>improvement principles.</p> <p>to the management of challenging behaviours, as the service introduced dementia level of care. The owner/manager reports they are in the process of commencing a clinical/quality administration role to further assist in the reviewing of the clinical policies and procedures (also confirmed in the business expansion plan for 2016). This review will include the review of the pressure injury management programme (refer to 1.3.6.1).</p> <p>All documents have a version control footer that includes the date when the policy was last reviewed. The document control system ensures that obsolete documents are removed from use. The review of policies or any updates are distributed to staff to read and they sign that they have understood any changes.</p> <p>Quality data collection and analysis is maintained by the service and evaluation of results shared with staff and management. Corrective actions are put in place where indicated. The internal audit form records the outcomes, actions needed, who is to implement the actions and the review of when the actions have been implemented. Follow up audits are conducted in designated timeframes to ensure the outcomes have been achieved. Data is collected and reviewed and evaluated for all key components of service (at the quality and risk meeting).</p> <p>The risk, hazard and emergency response plan identifies potential and actual hazards. The plan includes what the hazard is, potential harm, preventative actions and ways to eliminate, isolate or minimise the risk. The actions implemented are followed up to ensure the actions are achieving the desired results. A hazard identification form and the maintenance job request logs are used to record any new hazards. When new issues are identified, these are reviewed at the quality meetings.</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>	FA	<p>The owner/manager has an understanding of their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The pressure injury policy is under review and is yet to include the requirements of essential notification for stage three and above pressure injuries (also refer to 1.3.6.1).</p> <p>The service documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. Adverse events are reviewed and analysed on a monthly basis at the quality meeting. The adverse event forms are used for making improvements where required. The adverse event reports include a summary of the incident, immediate actions, corrective actions and outcomes.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes</p>	FA	<p>Professional qualifications and annual practising certificates (APCs) are validated on employment and annually. The service maintains a folder of current APCs which was sighted for all staff and contractors who require them, this is also part of the internal audit programme to verify APCs are current.</p> <p>The staff files evidence that good employment processes are implemented, such as recruitment, interview and</p>

are conducted in accordance with good employment practice and meet the requirements of legislation.		<p>reference checking. All staff files and staff interviews confirmed orientation is conducted and covers the essential components of care, service delivery, emergency management and health and safety. Performance reviews are conducted at least annually.</p> <p>The in-service education programme covers the essential components of service delivery for rest home and dementia level of care. The service links with another local aged care service to access ongoing education. The service also accesses ongoing education support from the gerontology nurse specialists and palliative care services. The in-service education programme includes skin care and pressure injury prevention and management (January 2016). The care staffing in the dementia unit meets contractual requirements for the required education related to the national unit standards for dementia care. The diversional therapist has completed specific training in dementia care, which includes the Spark of Life approach. Attendance records are kept for the education that staff have attended, as sighted in each of the staff member's personnel files. The RN who does the interRAI assessments has completed their training for this.</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 clearly documented policy on staffing levels and skill mix to meet the needs of residents requiring rest home and secure dementia level of care. There is at least one care staff on duty at all times in the dementia unit and rest home wings. In the dementia unit there is up to three staff on morning and afternoon shifts, with the shift times allowing more staff on duty during the busiest parts of the day and evening. The clinical nurse manager (who is a RN) and the RN are on duty Monday to Friday and share the on call role. There is a RN on call after hours and they come into the facility after hours as required to meet the residents' clinical needs.</p> <p>There is at least one staff member on duty each shift who has current first aid qualifications. Twenty two of the staff members have current first aid qualifications. There are appropriate staffing levels for activities, cooking and laundry. The diversional therapist oversees the activities programme, with most of the activities implemented by the care giving staff. The care giving staff confirmed they have adequate time to do their required work and all staff assist in implementing meaningful activities for the residents throughout their shifts.</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>	PA Low	<p>With the exception of the removal and replacement of expired medications, all aspects of medication management were consistent with legislation, protocols and guidelines.</p> <p>All staff who administer medications at the facility complete an annual medication competency assessment, as confirmed in staff records. An observation of a medication round confirmed that medications were administered in a safe and appropriate manner.</p> <p>All of the medication charts reviewed contained a current photograph of the resident, medications were appropriately prescribed, discontinued medications initialled and dated, three-monthly reviews of medication had been undertaken, and medication administration records were complete. The service is planning to review its</p>

guidelines.		<p>processes associated with assessing and ongoing review of self-medication competency.</p> <p>Evidence was sighted of medicine reconciliation being undertaken by an RN. Medications were stored securely. There were no controlled medications on the premises at the time of the audit visit. The date of first use of eye drops was recorded on those products currently in use.</p>
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	<p>Registered nurses complete a dietary profile for all residents at the time of their admission, which includes resident likes/dislikes and special nutritional needs. This information is then made available to kitchen staff. Residents are weighed monthly and nutritional supplements administered as prescribed. There are two separate small dining areas for rest home residents, or they may have meals in their own room if they wish. The dementia wing also has a dining area for residents. The meal trolley is taken around the facility, and meals plated for each individual resident immediately prior to serving. The meal service observed during the audit visit was unhurried, and time was taken to ensure individual resident's needs were met.</p> <p>The kitchen has a range of specialised crockery and cutlery available to promote resident independence, such as lip plates and feeding cups. A six-weekly menu cycle, with summer and winter options, was last reviewed by a registered dietitian in September 2015. The kitchen caters to a range of dietary requirements, such as diabetic, soft and vegetarian diets.</p> <p>On inspection, the kitchen was appropriately maintained. Cleaning schedules were sighted, together with records that fridge and freezer temperatures were monitored daily and remained within recommended ranges. Experienced and appropriately qualified staff are responsible for food services within the facility. The facility manager advised that food and safety training is provided for all staff on an annual basis.</p>
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	With the exception of behaviour management and diabetes management, resident's care plans reflected the outcomes of their interRAI assessments, were reviewed regularly, and progress towards achieving identified goals were regularly and thoroughly evaluated. Residents' progress notes are updated each shift. Registered nurses are on site at least 40 hours a week, and then available on call at all other times to provide support and guidance for care delivery staff. A doctor who visits the facility regularly expressed satisfaction with the standard of care provided to residents, while every resident and family member interviewed was very positive about care provision.
Standard 1.3.7: Planned Activities Where specified as part	FA	A qualified and experienced diversional therapist (DT) is on site 12 hours each week to lead the activity programme for both the rest home and the dementia wing. The DT is responsible for developing individual activity plans based on residents' previous and current interests. The DT then uses these assessments and plans to form

<p>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>the basis of the activity programme.</p> <p>A monthly activities programme is developed for both services, incorporating both individual and group activities. Written copies of the programme are available, with activities also listed on a large white board each weekly. The programmes are implemented by care delivery staff, with staff in the dementia wing having the flexibility to adjust the programme depending on residents' needs at the time. A record is maintained of resident participation in the activities programme. Activities include regular outings in the facility's van, exercises, happy hour, movies, quizzes, guest speakers and entertainers. Records were sighted of the monthly meetings between the facility manager and the DT in which the activity programme for the previous month is reviewed and new activities are planned. All residents spoken with during the audit visit expressed their enjoyment of the activities programme.</p> <p>Residents in the dementia wing have free access to a large and well-planned outside area, which offers a range of interesting and stimulating activities. Renovations are almost complete for an additional outside seating area for rest home residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All the long-term and short term care plans reviewed during the onsite visit had been consistently evaluated in a timely and thoughtful manner. There was evidence of long-term plans being reviewed at least six monthly, and earlier if clinically indicated. The evaluations clearly indicated resident progress towards achieving identified goals. Short term care plans were developed as clinically appropriate, and resident progress reviewed in a timely manner.</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>	FA	<p>There is a current building warrant of fitness displayed, this expires in November 2016. There have been no changes to the layout of the service that has required changes to the approved evacuation scheme.</p> <p>The landscaping, security locks on the courtyard gates, the external access from some residents rooms and the security fencing for the dementia unit are completed, this addresses the previous corrective action. The residents in both the rest home and dementia unit sections of the service have safe access to external areas. The layout of the dementia unit external areas provides an environment for residents to wander freely. The dementia unit and rest home have separated external areas. The residents and families reported satisfaction with the external areas of the service.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for</p>	FA	<p>The facility has a system for infection surveillance which is appropriate to the size and complexity of the service. The infection control coordinator, a registered nurse, collates the monthly surveillance data related to wound, urinary tract, upper respiratory tract, eye, gastro-intestinal and other infections. Surveillance data is gathered from</p>

<p>infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>records of antibiotic use, the development of short—term care plans related to infections, and information from the written handover sheets.</p> <p>Surveillance results are reported to the monthly quality and infection meetings, as was seen in the minutes reviewed. Results are discussed with staff at handover meetings, and at the monthly staff meetings.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are no restraints or enablers in use at the time of audit. The service does have some residents with a bed loop on their bed, to assist the resident to turn and get out of bed, this devise is a mobility aid and not classified as an enabler, as it does not restrict the resident's movement. If enablers are used, the restraint minimisation policies record that these will be voluntary and the least restrictive option to maintain the resident's safety, comfort or independence. The secure dementia unit is designed to allow residents to wander freely and through management of challenging behaviours reduce the need for the use of restraint. Staff demonstrate knowledge of restraint minimisation, management of challenging behaviours and the use of enablers.</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)
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	<p>The service has a well-developed medication management system, with the exception of ensuring that all medications on site are within current-use by dates. All staff involved in medication management undergo annual competency assessment; medication charts were current, with evidence of at least three-monthly medical reviews; medications are stored appropriately and disposed of promptly when no longer required and medicine reconciliation is undertaken when medications are received into the facility.</p> <p>Over half of all pro re nata (as required) medications in the medication trolley and in the medication cupboards were past their expiry date.</p>	Medications have not been removed and replaced when they were past their expiry date.	Ensure all medications are within current use-by dates. 180 days
Criterion 1.3.6.1	PA	All residents' files reviewed contained detailed care plans which generally reflected the findings of interRAI assessments and other	The clinical records of	All residents' care plans

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>Moderate</p>	<p>assessments/referral information. There were several areas in which residents' care plans did not reflect interventions related to identified needs:</p> <ol style="list-style-type: none"> 1. The care plans for residents requiring Stage III dementia care did not include a comprehensive management plan related to behaviour management. Residents' behaviour was being documented in a timely manner, but their care plans did not include strategies for minimising and responding to those behaviours. 2. The care plans of two residents who were insulin-dependent diabetics did not include plans related to the management of their diabetes. Evidence was sighted that blood sugar monitoring was being undertaken appropriately, and insulin was being administered as charted. 3. Pressure area prevention and management is included in the facility's wound and skin care guidelines. The content related to pressure injuries is brief, and provides insufficient detail for staff to guide practice relating to pressure injury prevention and management. The guidelines were due for review in October 2015. 	<p>residents requiring Stage III dementia care do not include a comprehensive behaviour management plan.</p> <p>The care plans of two insulin-dependent diabetic residents do not include comprehensive diabetes management plans.</p> <p>Wound and skin care guidelines do not reflect current best practice to guide staff in the prevention and/or management of pressure injuries.</p>	<p>reflect their assessed needs.</p> <p>Pressure injury prevention and management guidelines reflecting best practice are available and implemented.</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.