

Briargate Healthcare 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:	Briargate Healthcare Limited
Premises audited:	Briargate Dementia Care Unit
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 3 June 2015 End date: 3 June 2015
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:	36

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

Briargate Dementia Care Unit is one of three facilities which are privately owned by a husband and wife team. The service provides secure rest home level care for up to 40 residents with dementia.

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

Three of the four previous areas identified as requiring improvement have been addressed by the service. Care planning still requires improvements to be made.

There are two new areas identified for improvement. (One area has had the improvement addressed from the previous audit but a new area for improvement has been identified).

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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The service has processes in place to facilitate effective communication with families. If required there is access to an interpreter service.

The service has a documented complaints management system which was implemented. There was one outstanding complaint at the time of audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Briargate Dementia Care Unit (Briargate) has their purpose, values, scope, direction and goals documented. Business processes related to planning services to meet residents' needs are identified. Residents and families/whānau interviewed confirmed their needs are identified and met in a coordinated and safe manner.

The quality management system included an internal audit process, complaints management, family/whānau satisfaction surveys and collection of data related to incident/accidents and infection control. Collected data is benchmarked against other like facilities by an outside agency. Documentation identifies that quality and risk management activities and results are shared among staff, residents and family/whānau as appropriate. Corrective action planning is implemented to manage any areas of concern or deficits identified.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements. The area for improvement from the previous audit related to staff performance appraisals has been fully addressed by the service.

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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Residents have an initial nursing assessment and care plan developed by the registered nurse (RN) on admission to the service. The service meets the contractual times frames for the development of the long term care plan. When there are changes in the resident's needs, a short term care plan is implemented to reflect these changes. The care plan evaluations are conducted at least six monthly and the evaluation is conducted on all aspects of the care plan, this is an improvement that has been implemented since the last audit. The previous area for improvement related to the documentation of minimising strategies for challenging behaviours has been partially implemented and still requires further improvement. There is a new area for improvement to ensure the daily care logs are accurate and fully completed.

The service has a planned activities programme to meet the recreational needs of the residents, with a focus on residents with impaired cognitive function. Residents are encouraged to maintain links with family and the community.

A safe medicine administration system was observed at the time of audit. The service has documented evidence that staff responsible for medicine management are assessed as competent. There were shortfalls noted in the recording of when medications are given and the consistency of the weekly checks required for controlled drugs which need to be addressed.

Residents' nutritional requirements are met by the service. Residents and family, likes, dislikes and special diets are catered for, with food available 24 hours a day. The service has a four week, summer/winter rotating menu which is approved by a registered dietitian.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness and documentation to identify how requirements are being met. There have been no changes to the building footprint since the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Policy identifies the service is restraint free. Staff undertake education related to avoiding the use of restraint when dealing with challenging behaviour. Policy clearly describes enablers as voluntary and the least restrictive option.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a monthly surveillance programme, where infections are collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings.

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	2	0	0
Criteria	0	37	0	1	2	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>	<p>FA</p>	<p>Policy and procedures are implemented by the service to ensure an effective and fair complaints process is implemented. A review of the 2014 and 2015 complaints documented in the complaints register identifies the timeliness of complaints management and that information is used as an opportunity to improve services. One complaint made to the Waitemata District Health Board in June 2014, related to the smell of urine at the facility, has corrective actions shown. Discussion with the owner confirms this is an ongoing issue and corrective action documentation included an increase in cleaning hours, regular six weekly carpet cleaning and discussion at staff meetings about how to encourage residents to use the toilet. There is one open complaint of a minor nature that has been responded to by the nurse manager but has yet to be closed.</p> <p>Family/whānau interviewed confirmed that complaints management was discussed during the admission process and that they understand how the process works. They stated that management operate an 'open door' and that it is easy to discuss any concerns they many have.</p> <p>Staff stated they follow all policy requirements related to implementation of verbal and written complaints. Complaints are a standing agenda item for staff meetings, as confirmed by meeting minutes sighted. They are also reported to the owner as they occur.</p>
<p>Standard 1.1.9:</p>	<p>FA</p>	<p>The service promotes an environment that optimises communication through the use of interpreter services as</p>

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>required and staff education related to appropriate communication methods with residents with cognitive impairment. There are some residents with English as their second language and effective communicating has been maintained as a number of staff are bilingual. Policies and procedures are in place if the interpreter services are needed to be accessed. Families confirm they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure is documented in the family communication sheets, on the accident/incident form and in the residents' progress notes. The files have a form in which the family indicates for what and when they would like to be informed of different types of incidents. Processes are in place for the identification and communicating with enduring power of attorney, advocates or guardians.</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 strategic and business plan sighted for 2013-2015 identified the mission statement and values of the organisation. Documented goals are reported against quarterly and fully reviewed annually. The last review occurred in December 2014. Risk management is included in the business planning process.</p> <p>One owner works at least two days a week at the facility. Staff confirmed that the owners are available by telephone at any time. One of the owners was present during the audit. The owners have two other facilities and have owned/operated Briargate since 2010. Clinical services are overseen by a registered nurse manager. There has been a change in the nurse manager and the current person has been in the role for one month. She has many years' experience in management within the aged care sector. She was not at the facility on the day of audit.</p> <p>Monthly formal meetings are held with the owners and all areas of service provision are discussed. Job descriptions identify management members' experience, education, authority, accountability and responsibility for the provision of services. Interviews with family/whānau confirmed their relatives' needs are met by 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 system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The service has a quality and risk management system which is understood and implemented by service providers. This includes the development and update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. Management processes are overseen by the owners and issues are discussed at documented management meetings. This information is used to inform ongoing planning of services to ensure residents' needs are met.</p> <p>Quality improvement data is benchmarked by an offsite agency against other like facilities and compared to previously collected data on-site. The benchmarking sighted identified the service statistics compare favourably and are better than other like organisations. The data results are discussed at the quarterly review meetings and used to identify how goals are either being met or not. One example relates to an increase in the number of falls which could be fully explained. The service shows how it continues to seek corrective actions to bring the number of incidents and accidents down. Corrective actions have included an increase in diversionary therapy hours and a</p>

		<p>change to staff task lists to ensure better on-floor coverage especially during a time clearly identified when the highest number of falls occurred. Evaluated data shows that since putting these corrective actions in place the number of falls have decreased. This process is on-going.</p> <p>Staff and family/whānau interviewed confirmed any concerns they have were addressed by management and verbal examples of quality improvements were given.</p> <p>Actual and potential risks are identified and documented in the hazard register. Newly found hazards are communicated to staff, family/whānau and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. New hazards are discussed at staff and management meetings as confirmed in meeting minutes sighted. This is verified in the minutes sighted for the quarterly family/whānau/resident 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>	<p>FA</p>	<p>Policy identifies that the organisation requires all incidents, accident and adverse events to be reported immediately. The service providers fully understood their obligations in relation to essential notification reporting and know which regulatory bodies must be notified. Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required.</p> <p>Incident and accident forms sighted were well documented and any corrective actions to be taken are shown on the forms used by the service. Corrective actions are documented and evaluated by the nurse manager and owners. The incidents and accident forms reviewed corresponded with information sighted in the residents' files reviewed.</p> <p>Family/whānau interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives. Residents' files have a form to identify what relative wish to be notified of and when.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice</p>	<p>FA</p>	<p>A review of policies and procedures and staff files identified that human resources management process are conducted in accordance with good employment practice and meet the requirements of legislation. Job descriptions are in place for all roles undertaken at the service. Professional qualifications are validated for staff who require them. Health care assistants (HCA) are required to hold or be working towards identified qualifications related to dementia care. Of the 13 HCAs currently employed 11 have completed recognised dementia care education and two have commenced dementia care papers.</p> <p>New staff receive an orientation/induction programme that covers the essential components of service delivery. There is an ongoing education programme in place which covers all aspects of service delivery. Documentation is kept on site in each staff member's file and is monitored by the administrator. This includes clinical staff holding a</p>

<p>and meet the requirements of legislation.</p>		<p>current first aid certificate.</p> <p>An area requiring improvement at the last audit, related to staff appraisals not being up to date, has been fully addressed by the service and all file reviews contained up to date appraisals to meet contractual requirements.</p> <p>Family/whānau interviewed stated the staff do a very good job and always present in a professional manner. As observed on the day of audit staff manage residents in a calm, professional manner. Staff confirmed the education offered assists them to meet the requirements of the role they are employed for in a manner that meets residents' needs. No negative comments were received on the day of audit.</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>Documentation sighted in policy and on staffing rosters identified that adequate numbers of suitably qualified staff are on duty to provide safe care and meet residents' needs. The service provides diversional therapy for 10 hours per day Monday to Friday and eight hours Saturday and Sunday. There are 64 registered nurses hours per week on the floor plus the registered nurse manager who works at least 40 hours per week.</p> <p>Dedicated cleaning and laundry staff work seven days a week.</p> <p>The owner reported that additional staff would be rostered to meet increased residents' needs and this was confirmed by staff interviewed. The review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed stated there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. They voiced their pleasure related to some staff task changes which have occurred that allows them to spend more quality time with residents.</p> <p>Family/whānau interviewed stated they feel all their relatives' needs are met in a timely manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Medicines for residents are received from the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines were securely stored. The temperature of the medicines fridges were recorded daily. The medicine signing sheets and controlled drugs register do not comply with legislation and guidelines.</p> <p>The medicine charts are reviewed by the GP at least three monthly, with this review recorded on the medicine chart. All prescriptions sighted contain the date, medicine name, dose and time of administration. All the medicine charts have each medicine individually prescribed. There is a specimen signature register maintained for all staff who administer medicines. All the medicine files have a photo of the resident to assist with the identification of the resident.</p> <p>There are documented competencies for all staff responsible for medicine management. Self-administration of medicines is not suitable or appropriate for residents living in the dementia unit.</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>A four week rotating menu with summer and winter variations has been reviewed by a dietitian within the last two years. The kitchen staff receive a copy of each resident's nutritional profile, which includes the resident's nutritional needs, wants, dislikes. Special diets are catered for. A summary of any special diet is recorded and displayed in the kitchen for staff to use as a reference when catering for meals. There is food and nutritional snacks available 24 hours a day. The families report they are satisfied with the food and fluid services that their relative receives. No concerns were expressed about unintentional weight loss.</p> <p>The kitchen process complies with current legislation and guidelines. Fridge and freezer recordings sighted met food safety requirements. The kitchen staff have undertaken food safety education.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>The previous audit identified areas requiring improvement to ensure the care plans recorded all required information for dementia care. This has been partially addressed and still requires further improvements and embedding into practice. Staff were able to describe some preventive measures they implemented to reduce the occurrence of challenging behaviours. The families interviewed reported satisfaction with the care provided and that the staff do manage their relative's challenging behaviours well and these have reduced since their relative has been living at Briargate.</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 is flexible and individualised and focusing on the promotion of quality of life. Staff demonstrated good knowledge and skill in minimising the need for restrictive practices through the management of challenging behaviour and redirection of wandering residents. The residents' files evidence consultation and involvement of the family. The family/whanau reported that the service 'excels' at providing a supportive relationship with the resident that reduces anxiety and maintains a sense of trust, security and self-worth.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	FA	<p>The weekly activities plan is developed based on the resident's needs, interests, skill and strengths. There is a planned activities programme run seven days a week. The activities programme covers cognitive, physical, cultural and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities that focus on sensory activities and reminiscence. The service provides easy access to outside/courtyard areas that enables the resident to wander safely. There are tactile objects</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>throughout the service and plants in the outside areas. Where possible residents' independence is encouraged to maintain links with family and community groups. Families are encouraged to attend activities. The family/whanau report that their relative enjoys the range and variety of planned activities.</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>The previous audit required an improvement in the details of what is recorded in the evaluation of care. This has been addressed. The evaluations sighted indicated the degree of achievement and progress towards meeting desired outcomes.</p> <p>The residents' files have documented evaluations for all of the issues in the care plan. These evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the desired outcomes.</p> <p>If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with their GP. Residents' changing needs were clearly described in their care plans. The staff interviewed demonstrated good knowledge of short term care plans and report that these are identified at handover.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires on 15 January 2016. There have been no changes to the building footprint since the previous audit.</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</p>	<p>FA</p>	<p>The infection control surveillance that is undertaken is appropriate to the size and complexity of a dementia service, as shown in the infection control programme. All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is clearly described in the quality plan and management meetings and describe actions taken to ensure residents' safety.</p> <p>The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease and actions taken to reduce infections. The analysis includes the feedback that is provided to staff. The management and staff meetings recorded actions that are implemented to prevent and reduce infections. The data</p>

specified in the infection control programme.		reviewed records that infections have now reduced.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policy identifies that enablers are voluntary and the least restrictive option. The service remains restraint free as confirmed in meeting minutes sighted and by staff and management during interview. The content of staff education related to restraint and behavioural management was sighted. Staff are required to attend education as identified during orientation and on a regular ongoing basis as identified by the education calendar.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA</p> <p>Moderate</p>	<p>There were safe and appropriate processes for the prescribing, dispensing, reconciliation and disposal of medicines. The medicine chart had the required information and detail to meet legislative requirements. There are improvements required in documenting when medications are given and the checking of controlled drugs. In five of 10 medication charts reviewed, there was at least one time when the medication was given and not signed for, or if not given the reason for withholding the medication. There was a controlled drug in the controlled drug safe and the register records that the last check of this medication was over three weeks ago.</p>	<p>The signing sheet is incomplete in five of the 10 medications charts. The controlled drug register does not consistently record the required weekly stock check.</p>	<p>Ensure all medications are signed as given. Ensure the weekly check of the controlled drugs is consistently conducted and recorded.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p>	<p>PA</p> <p>Low</p>	<p>The service meets the required time frames for initial and ongoing assessment and care planning, nursing evaluation and medical reviews.</p>	<p>The daily care logs were not</p>	<p>Provide evidence that</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>The service records daily interventions and care by the use of a daily care log. These logs record the care provided to each resident each shift. The daily care logs are not fully completed. There are some shifts that do not record the interventions undertaken that shift and another file that had this completed for a resident who was in hospital.</p>	<p>fully completed or accurate in four of the five files reviewed.</p>	<p>the daily care logs are accurate and completed each shift.</p> <p>180 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Although all care plans document all the needs of the resident not all have sufficient information in the plan relating to how to manage challenging behaviours. One of the five files reviewed had a detailed description of strategies for minimising episodes of challenging behaviours over a 24 hour period. The other files had basic information with no clear documentation of triggers and how to identify these before the challenging behaviour occurs. The behaviour logs do record how the resident responded to the interventions implemented once the behaviour has started and the de-escalation interventions worked. This information is not clear on the care plan. As this was an area previously identified for improvement the risk rating has been increased to moderate.</p>	<p>Four of the five care plans do not have adequate documentation of the strategies for minimising challenging behaviours and how to manage challenging behaviours over a 24 hour period.</p>	<p>Provide evidence that strategies for minimising challenging behaviours and how to manage these challenging behaviours over a 24 hour period is clearly documented.</p> <p>90 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.