# Age Care Central Limited - Maryann Rest Home

## 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 Health and Disability Auditing New Zealand 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Age Care Central Limited

**Premises audited:** Maryann Rest Home and Hospital

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

**Dates of audit:** Start date: 19 August 2015 End date: 19 August 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:** 47

# 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** |
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|  | 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 |
|  | 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

Maryann Rest Home provides rest home, hospital and dementia levels of care for up to 48 residents and on the day of the audit there were 47 residents. The service is managed by a chief executive officer, two clinical coordinators and one domestic services supervisor. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The service has addressed two of five shortfalls from the previous certification audit around informed consent, and advance directives. Improvements continue to be required around staff training, documenting care interventions, and aspects of medication management.

This surveillance audit identified that improvements are required around review of the quality plan, activity plans for dementia residents, wound documentation, and medication management.

## Consumer rights

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| 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. |

Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

The quality and risk management programme includes an internal audit programme, monitoring adverse events and a health and safety programme that includes hazard management. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. Education and training for staff is conducted regularly. Staff are supported to maintain their professional development portfolios.

The service has a documented rationale for determining staffing. Caregivers, residents and family members report staffing levels are sufficient to meet residents’ needs.

## Continuum of service delivery

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| 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. |

Residents are screened and approved prior to entry to the service. There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were reviewed at least six monthly. Resident files included medical notes by the contracted GP and visiting allied health professionals.

The diversional therapist and activities coordinator provide an activities programme for the residents that is varied, interesting and involves the families/whānau and community.

Medication policies comply with legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies.

All meals are prepared on site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents, family/whānau interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

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| 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. |

A current building warrant of fitness is posted in a visible location.

## Restraint minimisation and safe practice

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| 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 are currently no residents requiring enablers. Staff receive training on restraint minimisation and managing challenging behaviours.

## Infection prevention and control

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| 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. |

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 13 | 0 | 2 | 2 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 2 | 2 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in five of five residents’ files sampled (one rest home, two hospital, two dementia). The previous findings around advance directives and consent for medications are now being met by the service. Resuscitation plans were sighted in the files and were signed appropriately. Copies of EPOA were on all files and activated as required. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms are available at both entrances to the facility. Information about complaints is provided on admission. Interviews with six residents (four at rest home level of care and two at hospital level of care) and the family members confirmed that they understand the complaints process. They also confirmed that the managers and staff are approachable and readily available if they have a concern.  Three (minor) complaints have been lodged in 2015 (year to date). The complaints register included all information and correspondence related to each complaint. Timeframes for responding to each complaint was met and all three complaints have been resolved. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Ten accident/incident forms were reviewed with evidence of open disclosure documented. Family are kept informed of any accident/incident unless the resident has consented otherwise. Interviews with two registered nurses and three caregivers confirmed family are notified following changes in a resident’s health status. All six family interviewed (three with family at hospital level of care and three with family at dementia level of care) stated they were kept informed. Residents’ meetings provide a forum for residents to discuss issues or concerns on every aspect of the service. Access to interpreter services is available if needed.  Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The information pack is available in large print and can be read to residents who are visually impaired. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | Aged Care Central Limited is a company formed to manage the operations of Maryann Rest Home and one other aged care facility in Stratford. It is registered as a charitable entity under the Charities Act.  Maryann Rest Home provides care for up to 48 residents at rest home, dementia and hospital level care. At the time of the audit, there were 47 residents including 18 residents receiving dementia level care, 10 receiving rest home level care and 19 receiving hospital level care.  A mission statement, vision and goals have been determined. The organisation quality management plan (January 2014 – January 2015) is due for review. A chief executive officer (CEO) reports to a board of directors. He has a background in radiography and is also the mayor of Stratford. The previous nurse manager role has been replaced by two clinical coordinators/registered nurses (RNs). Both clinical coordinators have extensive aged care experience and both have been working at the facility for five years or more. There is a domestic services manager who is responsible for managing support services (e.g. kitchen, cleaning, laundry, maintenance).  The CEO and both clinical coordinators have maintained at least eight hours annually of professional development activities related to managing an aged care facility. |
| 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 improvement principles. | FA | Quality and risk management systems are in place (link #1.2.1.1). Interviews with all staff (three caregivers working across the rest home, hospital and dementia unit, two registered nurses, a cook, a diversional therapist and an activities coordinator) confirmed their understanding of the quality and risk management programme.  There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. A document control system to manage policies and procedures is in place.  The quality and risk management programmes includes an internal audit programme and data collection, analyses and review of adverse events including accidents, incidents, infections, wounds and pressure areas. A corrective action process is implemented where opportunities for improvements are identified. Quality data is being shared in the support staff meetings.  The health and safety programme includes policies to guide practice. Staff accidents and incidents and identified hazards are monitored.  Falls prevention strategies are in place including the analyses of falls and the identification of interventions on a case-by-case basis to minimise future falls. Selected residents wear hip protectors to reduce injury from falls and sensor mats are in place to reduce the number of falls. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Incident/accident forms are completed by staff that either witnessed an adverse event or were the first to respond. The resident is reviewed by the RN at the time of the event. Ten incident forms were reviewed and all were completed appropriately and in a comprehensive manner. The five residents’ files reviewed demonstrated all documented accident/incident forms for that resident, had the events documented in the residents’ progress notes.  Discussions with the chief executive officer and clinical coordinators confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resources policies to support recruitment practices. Current practising certificates were sighted for all health professionals. All six staff files randomly selected for review had relevant documentation relating to employment. Annual performance appraisals were completed.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service.  There is an education plan that is being implemented that covers all contractual education topics, and exceeds eight hours annually. Staff regularly attend education and training, which includes the topic of continence management. This is an improvement from the previous audit. All six RN’s have completed InterRAI training. Ten of the 11 caregivers who work in the dementia unit have completed the required dementia qualification.  There is a minimum of one care staff with a current first aid certificate on every shift. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. In addition to the rest home residents, the facility operates a day care programme where a maximum of three residents are on-site from 9am-3pm, five days a week. Staffing levels are adjusted appropriately.  The two clinical coordinators/RNs work Monday - Friday. A full time RN is on 24/7. Staffing levels meet contractual requirements. There are separate laundry and cleaning staff. Activities staff provide an activities programme seven days a week.  Staff reported that staffing levels and the skill mix were appropriate and safe. Residents and family interviewed advised that they felt there is sufficient staffing. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Ten medication charts were reviewed (two rest home, four hospital, four dementia). There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are used and comply with organisational policy and legislative requirements. There were no residents self-medicating on the day of audit.  Eight of ten medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. Improvements have been made in relation to three monthly medication reviews.  Not all medication charts reviewed had indications for use for “as required medications” documented. Not all residents with known allergies had these documented on their medication charts. |
| 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 at Maryann are prepared and cooked on site. There is a four weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met.  Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.  Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. The dishwasher is checked regularly by the chemical supplier.  All food services staff have completed training in food safety and hygiene and chemical safety.  There is evidence that there are additional nutritious snacks available over 24 hours in the dementia unit. |
| 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, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.  In the residents’ files reviewed short term care plans were commenced with a change in heath condition and linked to the long term care plan. Long term care plans were reviewed six monthly. Not all residents’ files reviewed had interventions documented for all identified care needs and dementia residents did not have activities plans recorded to cover the 24 hour period. The previous audit finding relating to documenting all care interventions remains.  Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP, dietitian and specialist involvement in wounds/pressure areas. There was one current wound with gaps around documentation. There were no pressure areas on day of audit.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required. |
| Standard 1.3.7: Planned Activities  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. | FA | The service has a qualified registered diversional therapist who oversees one activity coordinator who is currently completing her diversional therapy training. The activity team provide individual and group activities in the rest home, hospital and dementia care units. The monthly programme is an inclusive programme where residents from all units (as appropriate) are invited into the unit where the activity is appropriate or entertainment is being held. Some activities such as baking, specific entertainment and canine friends occur in all units. There are regular outings/drives, inter-home visits for all residents (as appropriate) and involvement in community events. One on one activities occur for residents who are unable or choose not to be involved in activities.  An activity profile is completed on admission in consultation with the resident/family (as appropriate). Activity plans sighted in five of five residents’ files had been reviewed six monthly at the same time as the care plans were reviewed. There were no 24 hour activity plans documented in the residents’ files reviewed from the dementia unit (link #1.3.6.1). Activity participation sheets were maintained in the files sampled. Families are invited to the resident meetings. The service also receives feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families.  Care staff were observed at various times through the day diverting residents from behaviours in the dementia unit, and participating in one on one activities with residents in the rest home and hospital areas. The individual activities observed were appropriate for older people. There are resources available for care staff to use for one on one time with the resident.  Relatives and residents stated they were satisfied with the activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the residents’ files reviewed all initial care plans were documented and evaluated by the RN within three weeks of admission. Long term care plans had been reviewed at least six monthly or earlier for any health changes. There was evidence that the multidisciplinary team (MDT) including the GP, had been involved in all care plan reviews. The GP reviews the residents at least three monthly or earlier if required. Evidence of three monthly GP reviews were seen in all residents’ files sampled. On-going nursing evaluations occur daily/as indicated and are documented within the progress notes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry date 3 May 2016). |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings (link 1.2.3.6). There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. There have been no outbreaks. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers including definitions. A clinical coordinator/RN is the restraint coordinator and is knowledgeable regarding this role. During the audit there were no residents using an enabler. Eight hospital level residents were using restraint (bed rails only). Staff receive training around restraint minimisation and managing challenging behaviours. |

# 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.

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| **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 | A mission, vision, philosophy and goals are identified. The annual quality management plan is due for review. | The annual quality management plan (January 2014 – January 2015) is due for review. | Ensure the quality management plan is regularly reviewed and updated as goals are achieved.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | An annual education and training plan is being implemented, meeting contractual requirements. Staff report that they are supported in their professional development. One care staff who works in the dementia unit has not completed her dementia qualification. | Eleven care staff work in the dementia unit. One of the eleven staff who has been working for the service for over one year is enrolled but has not completed her dementia qualification. | Ensure all care staff working in the dementia unit completes their dementia qualification within one year of employment.  90 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 Moderate | In the medication files reviewed the GP had prescribed all medication to be administered to the resident on admission and then reviewed the medications prescribed at least every three months. Eight of ten medication charts had documented indications for use for “as required medications”. Orange allergy alert stickers are used on the medication charts to alert staff to any allergies the resident may have, as seen on nine of ten medication charts reviewed. | i)Two of ten medication charts reviewed (one rest home, one hospital) had as required medications prescribed with no indications for use documented; ii) one of ten medication charts reviewed (dementia) did not have medication allergies documented. | i) and ii) Ensure medication documentation and administration practices meet current legislative requirements and safe practice guidelines.  60 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 | Assessments are completed on admission, when the care plan is reviewed and with a change in health condition. Nursing care interventions were recorded for four of five residents. Two dementia resident files reviewed did not have activities plans recorded for the 24 hour period.  The RN reviews information gathered through the use of monitoring charts to ensure interventions are documented in the care plans to reflect current care needs.  Wound assessments, and interventions were documented for one of one current wound (one chronic ulcer). Adequate pressure management equipment and supplies were sighted. | i) One of five files (dementia resident) was noted by the speech language therapist to be at risk of choking. The long term care plan did not have interventions documented to manage this risk; ii) two dementia residents did not have an activities plan documented on their file to manage potential behaviours over a 24 hour period. (iii) one wound care plan reviewed (rest home tracer), did not have on-going assessments of the wound or evaluations of wound care documented. | i) Ensure there are documented interventions to meet all identified care needs; ii) ensure that all residents in the dementia unit have individualised 24 hour activity plans documented.  60 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.