Radius Residential Care Limited - Althorp

Introduction

This report records the results of a Provisional 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.

The specifics of this audit included:

Legal entity:	Radius Residential Care Limited
Premises audited:	Althorp
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 22 September 2015 End date: 22 September 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: 116

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.

General overview of the audit

Althorp private hospital is a privately owned aged care facility. The service is currently governed by three directors (registered nurses) and has a general manager (registered nurse) to manage the onsite services. Althorp private hospital provides hospital, dementia and psychogeriatric level of care across separate seven units. There is also a nine bed transitional acute care centre (TAC) providing short term rehabilitation, respite and palliative care services. There are a total of 117 beds available. Residents and families interviewed were very complimentary of care and support provided.

This audit was undertaken to establish the level of preparedness of a prospective provider to provide a health and disability service and to assess conformity prior to a facility being purchased. It comprised an interview of the prospective new provider. The service recently had an onsite visit (certification audit) undertaken on 13 and 14 May 2015. The audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and a general practitioner. The current manager is well experienced and qualified for the role and will be remaining in position with the new owners. The new owners, Radius Residential Care Limited, have 19 other facilities. The organisation has comprehensive

policies and procedures with which to guide staff. It is Radius's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership which will see the implementation of Radius policies and procedures.

Improvements are required in relation to an aspect of the quality programme, aspects of care planning and aspects of medication.

Consumer rights

The staff at Althorp private hospital ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent and advanced directives are documented. Complaints and concerns are managed and a complaints register is maintained.

Organisational management

The new owners of Althorp private hospital are experienced providers of aged care services. Radius has a strong an established organisational structure. The organisation has a transition plan in place to facilitate the smooth transition between owners with the least disruption of services for staff and residents which includes the ongoing employment of the current manager. The facility will be overseen by a regional manager with implementation of Radius policies and procedures to be rolled out.

Althorp private hospital has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with recent evidence of benchmarking outcomes with national standards. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that

provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Continuum of service delivery

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/whanau input. Care plans viewed demonstrated service integration and were reviewed at least six monthly. Resident files include medical notes by the contracted GP, psychogeriatrician and allied health professionals including the service physiotherapists.

Medication policies reflect legislative requirements and guidelines. The medicines records reviewed included documentation of allergies and sensitivities and have been reviewed at least monthly by the general practitioner/psychogeriatrician.

A diversional therapist oversees the activity programme for each unit. There is an activity assistant for each unit. Residents and families report satisfaction with the activities programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each consumers group.

The food service is provided by a contracted service. All food and baking is done on site. All residents' nutritional and dietary needs are identified and documented. Alternative choices are made available. A dietitian has reviewed the menu plans. Nutritious snacks are available 24/7 in the psychogeriatric and dementia care units.

Safe and appropriate environment

Chemicals were stored securely throughout the facility. The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Each bedroom has an ensuite. Communal areas within each area are easily accessed with

appropriate seating and furniture to accommodate the needs of the residents. External areas for each unit are safe and well maintained. There is a safe external walking path and gardens for the dementia and psychogeriatric care residents that is freely accessible.

Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility temperature is comfortable and constant. Electrical equipment is checked annually. All medical equipment and all hoists are serviced and calibrated annually. Hot water temperatures are monitored.

Restraint minimisation and safe practice

There is a restraint policy that includes comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were four residents requiring restraints and two residents using enablers. The service reviews restraint as part of the quality management and staff are trained in restraint minimisation.

Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. 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.

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	45	0	5	0	0	0
Criteria	0	96	0	5	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with staff (six healthcare assistants, five clinical team leaders, two registered nurses, one diversional therapist one chef manager, two domestic staff, one physiotherapist and one quality/education coordinator) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Seven residents (six hospital and one transitional) and 11 relatives (two hospital, seven psychogeriatric and two dementia) were interviewed and confirmed the services being provided are in line with the Code.
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 consent is obtained as part of the admission agreement. Advance directives if known were on the resident files. Copies of the enduring power of attorney were in 11 of 12 resident files sampled (four psychogeriatric, two dementia, five hospital). The resident in a transitional active bed has a resuscitation status made by the resident.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents' and separate family meetings three monthly include discussing previous meeting minutes and actions taken (if any) before addressing new items. The service has a trust of family members that act as advocates for other relatives if required. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Althorp has a relatives Trust which was established by a group of relatives to enhance the quality of life for residents. There are currently four members on the trust who meet with the general manager monthly. The focus of the trust is to improve the environment so as to add quality of life for residents, act as residents advocates, and to provide support and advice for other relatives. The trust is active in raising funds to go towards environmental improvements and purchasing of equipment.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures is implemented and residents and their family/whanau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is maintained. Seven complaints were received in 2014 and one complaint to date received in 2015. Systems and processes are in place to ensure that any complaint received is managed and resolved appropriately. All complaints have been managed with resolution documented. Residents and family members advised that they are aware of the complaints procedure and how to access forms. There is written information on the service - philosophy and practice for dementia care - particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible

		programmes, with emphasis on minimising restraint, behaviour management, and complaint policy.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well-informed about the code of rights. Resident and relative meetings and a resident and relative survey provide the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and are available at reception.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Church services are held weekly and resident files include cultural and spiritual values. There is a chapel on site. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has a Maori heath plan and an individual's values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There were seven residents at Althorp who identified as Maori. The service has established links with local Maori and there is a strong involvement in the Kaupapa ward at Tauranga hospital. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. The service has a number of staff who identify as Maori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and	FA	Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family

respect their ethnic, cultural, spiritual values, and beliefs.		involvement is encouraged.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules and a service code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Registered nursing staff have completed training around professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The quality and education coordinator is responsible for coordinating the internal audit programme. A variety of staff meetings and residents meetings are conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the general manager and senior management team. Care staff complete competencies relevant to their practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. Family complete a client incident notification form indicating when they wish to be contacted. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident and relative meetings occur three monthly and the general manager and clinical team leaders have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service works closely with the mental health service team prior to entry to psychogeriatric services. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English the interpreter services are made available. All residents were English speaking on the days of audit. A site specific Introduction to dementia and psychogeriatric units pamphlet providing information for family, friends and visitors visiting the

		facility is included in the enquiry pack along with a resident's handbook providing practical information for residents and their families.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	This provisional audit was conducted to assess the preparedness of new owners for the facility and included an interview with the new CEO, the new area manager and review of the transition plan. The new owners, Radius Residential Care Limited, have 19 other facilities. The organisation has comprehensive policies and procedures with which to guide staff. It is Radius's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership which will see the implementation of Radius policies and procedures. The Radius regional manager will support the current management team to transition across to Radius processes and systems. Althorp private hospital currently has four shareholders and three directors. All three directors are registered nurses. One of the directors is the chief executive officer (CEO) who is based on site at Althorp. The service provides care for up to 117 residents at hospital/psychogeriatric (geriatric and medical) and dementia level care. Althorp Private Hospital is divided into seven units - three hospital level units totalling 58 beds, one dedicated dementia unit with nine beds and three units classified as psychogeriatric with a total of 56 beds. There are also nine beds funded by the Bay of Plenty District Health Board (BOPDHB) for palliative care (four beds), transitional acute care (two beds) and respite care (three beds). On the day of the audit, there were 116 residents in total with one permanent hospital bed vacant. There is a full time and part time physiotherapist employed. The service also has physiotherapy assistants. Occupational therapy services are available as required. Residents can retain their own general practitioner (GP) on admission or change to the house GP who has schedule visits twice week, is on call and visits more often as required. The service has a mission statement and philosophy. There is an overall current business plan (2015-2017) and risk management plan and a documented purpose, values, and direction. Althorp has developed annual quality goals including health and safety goals. Progress towards goals is reported through the monthly quality and staff meetings. The chief executive officer (CEO) is one of three directors. The CEO is a registered nurse with a current practising certificate. The

		general manager is a registered nurse with a current practising certificate. Both the CEO and general manager have a significant amount of experience in the aged care environment and regularly attend professional development courses and Aged Care Association meetings and conferences relating to the management of the service, which exceeds eight hours per year. The service is managed by an experienced general manager who has been in the role for one and a half years. The general manager reports monthly to the directors on a variety of management issues. The general manager is the secretary of the local New Zealand Aged Care Bay of Plenty branch and supports the ARC sector within the DHB. The general manager has attended a leadership management conference February 2015. The general manager is supported by the CEO, the quality/education coordinator, five clinical team leaders, registered nurses and care staff.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The CEO and quality coordinator provides cover during a temporary absence of the general manager. The clinical team leaders are on call for clinical matters.
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.	PA Low	The quality manual and the business, quality, risk and management planning procedure describe the Althorp private hospital's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the quality improvement meeting, and the various facility meetings. Monthly and annual reviews have been completed for all areas of service. Meeting minutes have been maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with registered nurses and healthcare assistants confirmed their involvement in the quality programme. Resident and relative meetings are held three monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2014 and 2015 to date has been completed. Medication safety audits have not been included in the audit schedule for 2014 and 2015. Areas of non-compliance identified at audits have

		been actioned for improvement. Specific quality improvements have been identified and benchmarking with national standards occurs on data collected. The service has implemented a health and safety management system. There are health and safety goals for 2015 documented. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. There is a death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death. Falls prevention strategies are implemented for individual residents. Residents and relatives are surveyed annually to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Overall results of 2015 residents and relatives' survey are positive. The service is addressing areas around the food service identified in the survey with positive feedback to date. The service was awarded an ACC tertiary level Work Place Safety Management Practice certificate in December 2013 effective until 31 December 2015. A hazard register is in place. All identified hazards have risk management strategies, such as minimisation, isolation or elimination. A hazard reporting process is in place. Hazard monitoring is included in the internal audit programme with evidence of monthly checks. Radius, the new owners intend to introduce the quality and risk management programme and policies and procedures that is well established in their other facilities as reported by the CEO.
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 and accident data has been collected and analysed. Discussions with the service and documentation reviewed confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service appropriately notified relevant authorities during an outbreak in 2014. A sample of resident related incident reports across all service levels for April 2015 were reviewed. All reports and corresponding resident files reviewed

		evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data with national standards.
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.	FA	The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates are kept. Fourteen staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 15 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Healthcare assistants are orientated by the quality coordinator and senior healthcare assistants through the buddy system. Annual appraisals are conducted for all staff. A completed in-service calendar for 2014 exceeded eight hours annually and a schedule is in place for 2015. Healthcare assistants have completed either the national certificate in care of the elderly or have completed or commenced an aged care education programme. The general manager, quality/education coordinator, clinical team leaders and registered nurses attend external training including conferences, seminars and education sessions with the local DHB. The organisation has a mandatory education programme with multiple sessions held every month. The quality/educator coordinator, registered nurses, and physiotherapy staff conduct education and training for staff. The quality coordinator is a trained assessor for an aged care programme and a New Zealand nursing council assessor. External presenters include nurse specialists from the Bay of Plenty District Health Board, the local hospice and the Health and Disability Advocacy Service. Managers attend aged care conferences and area meetings. Three of the clinical team leaders are being supported by Althorp to complete post-graduate paper is palliative care. Eight registered nurses have completed InterRAI training. Fifty nine of ninety five healthcare assistants have completed their New

		Zealand Qualification Authority (NZQA) certificates (level two through level four) in aged care. Thirty of forty healthcare assistants who work in the dementia and psychogeriatric homes have completed their NZQA dementia certificates and ten who have been employed for less than one year, are currently completing the NZQA Dementia Standards.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Althorp private hospital home and hospital has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The service employs 30 registered nurses, 13 enrolled nurses, two physiotherapists, three physiotherapy assistants, one full time qualified diversional therapist and seven full time diversional therapy assistant currently completing training. There are at least three registered nurses and seven healthcare assistants on duty at all times. There is sufficient staff observed to assist residents in the dining rooms with meals including activities staff. The full time general manager is also a registered nurse. Caregivers and residents and family interviewed advised that sufficient staff are rostered on for each shift. All registered nurses have been trained in first aid and CPR. Radius do not intend to make any changes to the current rosters at the present time.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Information containing sensitive resident information are not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts are stored in a separate folder.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are pre-entry and admission procedures in place. Residents are assessed on entry to the service and needs assessments were sighted in the 12 resident files sampled (five hospital – including one younger person, one transitional care, four psychogeriatric and two dementia care). The mental health services screen residents for admission to the psychogeriatric and dementia units. The service has a comprehensive information booklet for residents/families/whanau at entry. Eleven

		relatives (seven psychogeriatric, two hospital and two dementia care) and six hospital residents state they received sufficient information on the services provided. ARC; ARHSS D13.3 Twelve admission agreements reviewed aligns with a) -k) of the ARC contract. ARC; ARHSS D14.1 Exclusions from the service are included in the admission agreement. ARC; ARHSS D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement. E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack. 1. Minimising restraint. 2. Behaviour management. 3. Complaint policy E3.1 Two files reviewed include a needs assessment as requiring specialist dementia care. Four psychogeriatric resident files reviewed had needs assessments approved by the psychogeriatrician.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The transfer/discharge/exit procedures include a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation were forwarded with the resident.
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 Low	There are policies and procedures in place for safe medicine management that meet legislative requirements. RNs and enrolled nurses complete annual medication competencies and medication education. Registered nurses were able to describe their role in regard to medicine administration. Standing orders sighted were current. There were no self-medicating residents. D16.5.e.i.2; Twenty two medication charts sampled (four dementia, eight psychogeriatric, 10 hospital) identified that the GP had reviewed the medication charts three monthly. Two TAC unit medication charts had been completed by the resident own GP on admission. Indications for use for ‘as required’ medication was not documented on all 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	The meal service is contracted. The qualified Chef Manager (interviewed) is responsible for overseeing the food service and the staff. The menu has been reviewed by a dietitian. There is one main kitchen and all meals are cooled and prepared on-site. Meals are delivered to each unit plated in hot boxes with insulated trolley racks. The chef receives a dietary requirements form for each resident and notified of any dietary changes. Resident's likes and dislikes are known and alternative choices are offered. Pureed, soft, diabetic and gluten free diets are provided. Lip plates and specialised utensils are available as required to promote resident independence at meal times. Temperatures are monitored on chilled goods on delivery. End cooked food temperatures, fridge (including fridges in the units), freezer and chiller temperatures are taken and recorded daily. All foods are date labelled. Staff were observed wearing appropriate protective wear. Chemicals are stored safely. There is an opportunity for residents/relatives (as appropriate) to feed back on the food service at resident meetings and through satisfaction surveys. All food services staff have attended food safety and chemical safety training. ARHSS D15.2f: E3.3f; There is evidence that additional nutritious snacks are available in individual units over 24 hours.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry was declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, activities preferences, food and nutrition information. The RN completes an initial assessment on admission.

		Needs outcomes and goals of consumers are identified through the assessment process in consultation with significant others. The diversional therapist (DT) completes an activity assessment. Shortfalls were identified around behaviour assessments/management plans. E4.2a: Challenging behaviour monitoring was completed where required identifying de-escalation strategies.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Resident care plans reviewed were individualised, comprehensive and demonstrated service integration and evidence input from allied health professionals. All resident files evidenced resident (as appropriate) or relative participation in the care planning process. Relatives interviewed confirmed they were involved in the care planning process. Nutritional requirements are assessed (through InterRAI) on admission identifying resident nutritional status. Documentation shortfalls were identified around weight management interventions. ARHSS 16.3g: Three out of four psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies (# link 1.3.4.2). Behaviour charts and behaviour monitoring has been completed as appropriate for escalation in behaviours. D16.3k, Short-term care plans are used for short term needs, however were not in place for all noted acute health changes. Short term care plans sighted related to management for falls, skin tears and UTIs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required, GP 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 appointments. On admission family complete an incident notification form. Discussions with families and notifications are documented in the resident file. Adequate dressing supplies are available. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds and one pressure area (hospital). There is evidence of GP involvement and photos for chronic wounds. Chronic wounds have been linked to the long term care plans

		(link 1.3.5.2.). Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Four clinical team leaders (RN's) were able to describe access for wound and continence specialist input as required. ARHSS D16.4; There is good specialist input into residents in the psychogeriatric unit. Strategies for the provisions of a low stimulus environment could be described by the care team and diversional therapist.
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 diversional therapist (DT) who oversees a team of seven activity assistants. The DT attends, study days conferences and regional meetings. The DT team have all completed dementia unit standards and have current first aid certificates. As of January 2015 there has been one activity assistant per unit (hospital units, psychogeriatric units, dementia care unit and TAC/hospital unit), Monday to Friday 9.30-4pm. Each unit has a separate weekly programme and activities were observed occurring in each unit simultaneously. One on one time occurs on an individual basis throughout the 24 hour period. Care staff are also involved in activities. There is a variety of activities including (but not limited to): baking, crafts, bowls, men's shed, music, pampering, balloon therapy, gardening, walks, quizzes, happy hour, men's pampering, movie afternoons, reminiscing and newspaper reading. A wheelchair van is available for resident's outings (as appropriate) to concerts, drives and ice-creams, garden and woodwork shows as well as scenic lookouts. Community links are maintained with groups and individual visitors such as piano players, choirs, ukulele club, floral artist, SPCA, library and churches. Church services are held in each unit and the on-site chapel. ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered from the relative (and resident as able) is included in the activity care plan. ARHSS 16.5g.iv: Care staff were observed at various times through the day diverting residents from behaviours. Care staff complete a 24 hour activity sheet. The programme observed was appropriate for older people with mental health conditions and included residents involved in

		meaningful activities such as folding handtowels, knitting and enjoying cups of tea and one on one time with staff. Residents attend activities in other units as appropriate such as church service. All units are bright and homely with photos and books for reading. Relatives stated they were satisfied with the activities provided and that staff were involved in activities with their loved ones, even if only passive participation. An activity profile is completed on admission in consultation with the resident/family (as appropriate). Activity plans were sighted in all LTCP reviewed. These have been reviewed six monthly at the same time as the care plans. Activity sheets are maintained. Families are invited to the resident meetings. The service also receive feedback and suggestions for the programme through surveys and one on one feedback from residents and families.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long term care plans reviewed have been evaluated at least six monthly or earlier for any health changes. InterRAI assessments are in use. The multidisciplinary team (MDT) are involved in the care plan reviews. The MDT includes the clinical tem leader, resident/family as appropriate, DT, physiotherapist and any other allied health professionals involved in the care of the resident such as the community mental health nurse practitioner. The GP reviews the residents at least three monthly or earlier if required. The psychogeriatrician reviews the psychotropic medications for the psychogeriatric and dementia unit residents. On-going nursing evaluations occur daily/as indicated and have been documented within the progress notes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The files reviewed identified referral to other health and disability services. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to, mental health services for the older person, physiotherapist, occupational therapist, hospice and hospital specialists. The service liaises closely with the needs assessment team, geriatrician, psychogeriatric and mental health team. There was evidence of where two resident’s conditions had changed and the residents were reassessed from (1) dementia care to

		psychogeriatric care, and (2) from rest home to hospital care.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The service has in place Management of Waste and Hazardous Materials policy and relevant procedures to support the safe disposal of waste and hazardous substances. There is an incident reporting system that includes investigation of waste and hazardous types of incidents. Approved containers are used for the safe disposal of sharps. Chemicals sighted were labelled correctly and stored safely throughout the facility. Staff were observed wearing protective equipment and clothing carrying out their duties. Gloves, aprons and face shields are available for staff in the sluice rooms and laundry room. Relevant staff have attended chemical safety training. The chemical supplier provides safety data sheets and conduct quality control checks on the effectiveness of chemicals.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Althorp has a current building warrant of fitness that expires 22 November 2015. The maintenance person attends to daily maintenance and repairs as requested. There is a planned maintenance plan in place. The maintenance person is a certified electrical tester. Clinical equipment has been calibrated and had a function test. Hot water temperatures in resident areas are tested monthly. There is evidence of corrective action where temperatures have been above 45 degrees Celsius. The internal communal areas are spacious with wide corridors and rail appropriately placed. There is adequate space for residents to mobilise safely with the use of mobility aids. The external areas are well maintained with safe outdoor access. There is seating and shade in all outdoor areas. Psychogeriatric Units: There are quiet, low stimulus areas that provide privacy when required. Residents have the freedom to move safely around the unit. Each of the three psychogeriatric units have their own safe outdoor area and walking pathways that are easy and safe to access. Dementia Units: Residents (and their visitors) may use their bedrooms for privacy when required. A large outdoor area provides low stimulus and a quiet area with gardens and a men's shed. There is a secure

		outdoor garden and grounds area with safe pathways that are easily accessed by residents as observed on the day of audit. The main lounge is designed so that space and seating arrangements provide for individual and small group activities. Caregivers and RNs interviewed state there is adequate equipment in all units to carry out the cares as instructed in the care plans including (but not limited to); electric beds, sensor mats, pressure area mattresses and cushions, standing and lifting hoists, ceiling hoists in the hospital bathrooms, chair scales, shower chairs, specialised hospital level lounge chairs, mobility aids, wheelchairs, and gloves, masks and aprons.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All residents' rooms have ensuites. Flooring, fixtures and fittings are appropriate. Residents interviewed (as appropriate) confirmed staff ensured privacy was provided when attending to their personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All resident rooms are single and spacious. Residents can safely move around their rooms with the use of mobility aids. The rooms are of sufficient size to enable staff to safely use the hoist for resident transfers. Residents are encouraged to personalize their rooms. Rooms viewed on the day of audit were personalised.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Each unit has a dining area and lounge rooms. There is a large central diversional therapy room where supervised activities take place. Activities also occur in each unit. . Residents are able to move freely and furniture is well arranged to facilitate this. The kitchenette areas secure units have gates installed for resident safety. The service has a physiotherapy room and hydrotherapy pool which is well utilised. Psychogeriatric Units: There are three psychogeriatric units (15 beds in each). Each unit has an internal atrium (closed in for safety) with a water feature. The lounge area is designed so that space and seating arrangements provide for individual and group activities. Dementia Unit: Residents (and their visitors) may use their single bedrooms for privacy when required. Large outdoor areas provide low stimulus and quiet areas. There is adequate space to allow maximum

		freedom of movement while promoting safety for those that wander.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are dedicated laundry and cleaning staff on duty each day. There are defined clean and dirty laundry areas with an entry and exit door. Safety data sheets and product charts are available for staff. Laundry equipment is serviced and checked regularly. Cleaning trolleys are well equipped. Each unit has a designated locked cleaning cupboard. Residents and families interviewed are satisfied with the cleanliness of the environment and bedrooms. The chemical provider conducts regular checks on the effectiveness of cleaning and laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The service has a fire and emergency procedures manual. The New Zealand Fire Service has approved the evacuation scheme 24 October 2013. Trial evacuations are completed six monthly. There is a staff member with a first aid certificate on each shift. Fire safety training has been provided. Call bells are available in all bedrooms, ensuites and communal areas. Visitors and contractors sign in at reception when visiting. Civil defence and first aid resources are available. Sufficient water is stored for emergency use and alternative heating and cooking facilities are available. Emergency lighting has a two hour battery time. The facility has a large capacity generator on site. Staff interviewed could describe the civil defence procedure and location of the civil defence resources.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	There is adequate light and ventilation in all bedrooms and communal areas. The facility has ceiling panels for heating. Residents and families interviewed confirmed the environment is warm and comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Althorp private hospital home and hospital has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and is linked into the incident reporting system. The quality/education coordinator (registered nurse) is the designated infection control nurse with support from the general manager, clinical team leaders and the quality team. IC matters are discussed at the quality and health and safety meetings. Minutes of meetings are available for staff to read.

		Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme at Althorp private hospital home and hospital. The infection control (IC) nurse has maintained her practice by attending infection control updates. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control/quality team and training and education of staff. The policies are reviewed and updated at least two yearly.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The service is committed to the on-going education of staff and residents. Education is facilitated by the infection control nurse with support from the general manager and clinical team leaders. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and were advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014 and 2015.
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	Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. Systems in place are appropriate to the size and complexity of the facility. A registered nurse (quality/education coordinator) is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution.

		Surveillance of all infections is entered on to a monthly facility infection summary and staff are informed. The data has been monitored and evaluated monthly and annually. An outbreak in 2014 was appropriately managed, with notification to the relevant authorities.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation is overseen by a restraint coordinator who is the quality/education coordinator. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. There were four residents requiring restraint (one hospital with bedrails, two psychogeriatric with lap belts and one psychogeriatric with a bean bag). There were two residents with bedrail enablers. The use of enablers is voluntary, requested by the resident. A full restraint assessment is completed prior to implementing the enablers. There is evidence of the residents consenting to the enabler. In addition, there is evidence of monitoring of residents who were using enablers. Two files of residents using bedrail enabler (two hospital) were selected for review. There was documented evidence of an assessment for the use of the enabler, voluntary, written consent was provided by the resident and the use of this enabler linked to the resident's care plan.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint coordinator is the quality/education coordinator (registered nurse). Assessment and approval process for a restraint intervention included the restraint coordinator, registered nurse, resident/or representative and medical practitioner.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, a registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the six files reviewed (four restraint and two enablers), assessments and consents were fully completed. Consent for

		the use of restraint was completed with family/whanau involvement and a specific consent for enabler / restraint form was used to document approval.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identified that restraint is only put in place where it was clinically indicated and justified and approval processes. There is an assessment form/process that was completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. Six files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. The service has a restraint and enablers register which is up dated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every six months and monthly at the quality meeting. In the files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator at quality and staff meetings meeting. Evaluation timeframes are determined by risk levels. The evaluations have been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six monthly or sooner if a need is identified by the restraint co-ordinator. Restraint/enabler use is discussed at the resident's multi-disciplinary review. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly meetings. Restraint is part of the monthly quality meetings.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	The service has an implemented audit schedule with key components of service delivery linked to the quality system that has been completed for 2014 and 2015 to date. Audits include but not limited to; health and safety, building maintenance, falls data, continence, medication errors, wound care, pain, pressure area, restraint and assessments and care plans. The service has not included medication safety audits as part of the audit schedule for 2014 and 2015. The service identified a number of medication errors for the 2013 and 2014 year. A medication error report was completed and	The service has not included medication safety audits as part of the audit schedule for 2014 and 2015. The service identified a number of medication errors for the 2013 and 2014 year. A medication error report was completed and presented to the quality meeting February 2015 with recommendations including staff training and therefore the risk has been identified as low.	Ensure that medication safety audits are included in the audit schedule so as to monitor key service delivery and address areas of non-compliance. The service during the audit days has included a medication safety audit in the 2015 audit schedule to be completed May 2015. 90 days

		presented to the quality meeting February 2015 with recommendations including staff training.		
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	Each resident medication chart has photo identification and allergy status identified. Each medication charted is dated and signed by the GP. The psychogeriatrician reviews the psychotropic medications for the psychogeriatric residents.	Eleven of twenty four medication charts (four dementia, three psychogeriatric, two hospital and two TAC unit) did not have 'indications for use' documented for 'as required' medication	Ensure all as required medications have an indication for use. 90 days
Criterion 1.3.3.3 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.	PA Low	Ten of twelve resident files sampled identified the long term care plan had been developed within three weeks. One resident was on a short term contract.	The long term care plan had not been developed within three weeks for a permanent resident in the psychogeriatric unit.	Ensure long term care plans are completed within three weeks. 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for	PA Low	The needs and outcomes of risk assessments for falls, pressure area, continence, pain, wound and restraint as applicable are documented in the 12 resident care plans sampled. Behaviour monitoring charts are available to monitor behaviours.	(i) Psychogeriatric: ARHSS D16.5gii One out of four resident files sampled had no behaviour assessment/management plan completed on admission. (ii) Dementia: E4.2; One of two dementia resident files reviewed did not have an individual behaviour	Ensure behaviour assessments/management plans are completed on admission and for altered/escalated behaviours. 90 days

service delivery planning.		Behaviour assessment /management plans were in place for three out of four psychogeriatric files and one out of two dementia files sampled.	assessment/management plan in place identifying diversional, motivation and recreational requirements over the 24 hour period. (iii) There was no behaviour assessment/management plan or behaviour monitoring in place for one hospital resident with altered behaviour.	
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.	PA Low	The long term care plans reviewed had been developed within three weeks of admission. Ten of 11 permanent resident care plans identify the required support to meet the resident's needs/goals. One TAC resident file sampled had a TAC care plan completed that described support needs required for full rehabilitation.	(i) The long term care plan for one hospital resident did not reflect current supports regarding mobility as per the physiotherapist assessment. (ii) D16.3k, Short-term care plans for acute changes in health were not in place for; a) one hospital resident on medication for depression, and b) TAC resident with oedematous legs, and c) no wound care plans for five on-going wounds. (iii) There were no documented interventions for two of four psychogeriatric residents and one of four hospital residents with weight loss	i) Ensure care plans reflect the resident's current needs and supports. ii) Ensure short term care plans are completed for acute changes in health status; (iii) Ensure interventions to manage weight loss are documented. 90 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.

No data to display

End of the report.