

Evelyn Page Retirement Village Limited

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by 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:	Evelyn Page Retirement Village Limited
Premises audited:	Evelyn Page Retirement Village
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: 20 July 2015 End date: 21 July 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:	119

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Evelyn Page Village is a Ryman Healthcare facility. The facility provides rest home, hospital and dementia level of care for up to 137 residents including 20 certified serviced apartments for rest home level care. On the day of audit there were 119 residents - 116 residents in the care centre and three residents in serviced apartments.

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. This 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 continued to implement a number of quality improvements.

The previous certification shortfalls around restraint documentation, interventions related to behaviour monitoring and medication fridges have been addressed.

This audit identified an improvement around aspects of documented interventions.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Complaint processes were being implemented and complaints and concerns were managed and documented. The service practices open communication with residents and families and concerns have been managed and a complaints register is maintained. There is documented evidence of relative notification for any changes in health.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Evelyn Page is implementing the Ryman Accreditation Programme that provides the framework for quality and risk management. Key components of the quality management system linked to a number of meetings including staff meetings. An annual resident/relative satisfaction survey was completed and there have been regular resident/relative meetings. Quality and risk performance was reported across the various facility meetings and to the organisation's management team. Evelyn Page provided clinical indicator data for benchmarking for the three services being provided (hospital, rest home and dementia care). There were human resources policies including recruitment, selection, orientation and staff training and development. The service had an induction programme in place that provided new staff with relevant information for safe work practice. There was an in-service training programme covering relevant aspects of care and support and external training was supported. The organisational staffing policy aligned with contractual requirements and included skill mixes.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nursing staff are responsible for each stage of service provision. The assessments and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the rest home, hospital and dementia care residents.

Medication polices reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. The medication charts reviewed meet prescribing requirements and were reviewed at least three monthly.

Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. Nutritious snacks are provided 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is in place.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy in place with associated procedures and forms. The policy contains definitions of restraint and enablers that are congruent with the definitions included in the standards. The clinical manager/restraint officer oversees restraint/enabler usage within the facility. The service currently has three residents using a restraint and two residents voluntarily using enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme was appropriate for the size and complexity of the service. The infection control officer/RN uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engaged in benchmarking with other Ryman facilities.

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	16	0	1	0	0	0
Criteria	0	39	0	1	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy is being implemented at Evelyn Page. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. Five complaints to date (two special care unit, two rest home and one hospital) have been managed appropriately and to the satisfaction of the complainant. Concerns and complaints are discussed at relevant meetings. One coroner case remains open since October 2013. The district health board has been kept informed. Discussions with nine residents (five rest home and four hospital) and seven relatives (two hospital, four special care unit and one rest home) confirmed they were provided with information on the complaints process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Evelyn Page enters incidents into the Ryman V-Care system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed on the V-care system met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. Resident meetings are held regularly. A family meeting held</p>

		recently with management evidenced discussion around facility matters, quality improvements and goals. There was an interpreter policy and contact details of interpreters were available.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Evelyn Page is a Ryman Healthcare retirement village. The service provides rest home, hospital level and dementia level of care for up to 117 residents in the care centre. Twenty serviced apartments have also been certified as suitable to provide rest home level care. On the day of audit there were 119 residents - 116 residents in the facility including 20 rest home (19 permanent residents and one respite care), 58 hospital level residents (55 permanent, two respite care and one medical) and 38 dementia care residents. There were three rest home residents in serviced apartments.</p> <p>Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Quality objectives and quality initiatives from an organisational perspective are set annually and each facility then develops their own specific objectives. The quality objectives are reviewed annually. Quality improvements at Evelyn Page include (but not limited to); increased attendance at meetings and in-services, improved resident and relative communication and development of a leadership team. A translation project initiated at Evelyn Page involves staff of many nationalities sharing their culture, involving staff in international months and improving interpretation of information and communication with residents, staff and families. Objectives for 2015 include aged care education units for registered nurses, installation of Wi-Fi tablets in each resident room for clinical care and involving volunteers in the activity programme.</p> <p>The village manager at Evelyn Page has been in the role for 18 months and is supported by an assistant manager. Both managers were in key positions prior to their appointment and have completed leadership development training. The non-clinical team is supported by a regional manager. A clinical manager who has been in the role three years has overall responsibility for clinical management of the three service levels.</p> <p>The village manager has maintained at least eight hours to date of professional development activities related to managing a village.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	FA	<p>Evelyn Page is implementing the Ryman Accreditation Programme (RAP) which links key components of the quality management system to village operations. Full</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>facility RAP meetings are held monthly.</p> <p>Outcomes from the RAP committee are then reported across the various meetings including the full facility, registered nurse and journal club, care assistants and support services. Meeting minutes include discussion about the key components of the quality programme including policy reviews, internal audit, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). Management meetings are held weekly. Health and safety and infection control meetings are held two monthly. Interview with 17 staff confirmed an understanding of the quality programme. “Huddles” (informal meetings) have been implemented and occur daily between the teams with a positive effect on team communication.</p> <p>Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced based practice. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to be completed to maintain competency.</p> <p>A relative survey was last completed in March 2014. Results have been collated. Areas of improvement identified were communication and laundry services in comparison with 2014 results.</p> <p>Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is evidence of trending of clinical data, and development of QIPs when outcomes exceed targets – e.g. falls. Falls prevention strategies are in place that include a “traffic light” system, intentional rounding, post falls response protocol, ongoing falls assessment and exercises by the physiotherapist, sensor mats, fall prevention pamphlets and appropriate footwear. The service has a “lounge assistant” in the hospital and dementia care unit to monitor high falls risk residents.</p> <p>The service has a current risk management plan. A hazard register is maintained.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Evelyn Page staff collect incident and accident data and complete electronic recording of events on the V-Care system. Monthly analysis of incidents by type is undertaken by the service and reported to the various staff meetings. Data was linked to the organisation's benchmarking programme and used for comparative purposes. QIPs were created when the number of incidents exceeded the benchmark. QIPs were seen to have been actioned and closed out. Senior</p>

		management were aware of the requirement to notify relevant authorities in relation to essential notifications. There is evidence of notification to the relevant authority for an outbreak (gastrointestinal) in April 2015.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are organisational policies to guide recruitment practices and documented job descriptions for all positions. Appropriate recruitment documentation was seen in the nine staff files reviewed. Performance appraisals were current in all files reviewed. Interview with care assistants and registered nurses (RN) advise that management are supportive and responsive. All newly appointed staff complete general induction and role specific orientation.</p> <p>An annual training plan which aligns with the RAP is being implemented. All care staff commence foundation skills on employment. The service has two workplace assessors employed to support staff through unit standards. There are 70 staff (including support staff) progressing through the units standards. Staff have access to external training and on-line training. A register of current practicing certificates is maintained for qualified staff.</p> <p>The clinical manager and five RN's have completed InterRAI training and 50 residents have interRAI assessments completed.</p> <p>Five of 11 care staff who are employed in the dementia care unit have completed their dementia specific units. The remaining 6 staff have commenced dementia specific units within the required timeframe and have been employed less than one year.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The care centre is overseen by a fulltime clinical manager. Each unit in the care centre has a RN Unit coordinator. The serviced apartment coordinator is an enrolled nurse. There is at least one registered nurse on duty 24/7. Interviews with care staff confirmed that the registered nurses are supportive and approachable. Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs. A weekend receptionist has been employed. One of the management team is on-site on Saturdays.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised medication blister packs for regular and as needed (PRN) medications. Medications are managed appropriately in line with required guidelines and legislation. The service has addressed the previous finding relating to medication fridge temperature monitoring and corrective actions. Medication reconciliation is completed on delivery. All clinical staff who administer medication 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 not used. Three self-medicating residents had been assessed by the GP and RN as competent to self-administer.</p> <p>All 14 medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The meals at Evelyn Page are all prepared on site. There is a four weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The cook receives resident dietary information from the RN's and is notified of any changes to dietary requirements (vegetarian, moulied foods) or of any residents with weight loss. The assistant cook (interviewed) is aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day.</p> <p>Food safety management procedures are adhered to including storage of food, and temperature monitoring. Staff were observed wearing correct personal protective clothing in the kitchen. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses.</p> <p>The residents interviewed are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings and through resident surveys.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>InterRAI assessments tools are used for any change in health condition and to develop the long term/short term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. Six long term care plans sampled evidenced that interventions were fully recorded and aligned with the resident's assessed needs. One hospital respite file sampled did not have interventions fully recorded to meet the resident's needs. The previous certification audit finding around interventions for behaviour monitoring has been addressed and monitored.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds, (four skin lesions, one skin tear, and five chronic wounds). There is one resident with a pressure area (grade one). Pressure area prevention strategies are included in the long term care plan. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. Staff receive regular education on wound management.</p> <p>Short term care plans are utilised for short term care issues including changes in health conditions, infections and wounds which are documented in the electronic V-care plan.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the care staff interviewed.</p> <p>The clinical files sampled evidenced involvement of referral to allied health and specialist serves as required including speech language therapist, physiotherapist, dietitian, skin specialist, podiatrist, and wound care specialist.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are five activity co-ordinators who provide a separate Monday to Friday activity programme for the rest home, hospital, dementia care units and serviced apartments. A company diversional therapist (DT) oversees the activity programmes. The activity co-ordinators attend Ryman workshops and on-site in-services. All hold current first aid certificates. Four of the activity team have commenced training towards DT qualifications. The programme is planned monthly and includes Ryman minimum requirements for the "Engage" activities programme. Activities programmes are displayed on notice boards around the facility and a monthly calendar is delivered to each individual resident. There is a core</p>

		<p>programme which includes the triple A (Active, Ageless, Awareness) exercise programme. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. One on one time is spent with residents who are unable to actively participate in the activities. A variety of individual and small group activities were observed occurring in the dementia care units at various times throughout the day of audit. Residents in serviced apartments can choose to attend the serviced apartment or rest home/hospital activities. Entertainment and outing are scheduled weekly. Community visitors are included in the programme. Residents are assessed, and with family involvement if applicable, and likes, dislikes, and hobbies are discussed. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment and outings. Resident meetings are held two monthly and family meetings six monthly. There is an opportunity to provide feedback on activities at the meetings and six monthly reviews. Resident and relative surveys also provide feedback on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The evaluation and care plan review policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan. Six long term care files sampled of permanent residents contained written evaluations completed six monthly. The seventh file was respite care. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems. On- going nursing evaluations occur daily and/or as required and are documented in the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The service displays a current building warrant of fitness that expires 6 September 2015.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections were in place appropriate to the complexity of</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>service provided. Infections were included on a register and a monthly report was completed by the infection control officer (RN). Infection control data is entered onto the V-care on-line system. The service receives monthly data reports which are reported to the combined infection control and health and safety meetings. Organisational benchmarking occurs. Staff are informed on infection control matter, trends and quality improvements through the variety of meetings held at the facility. The infection control programme is linked with the RAP. The infection control officer used the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. There is close liaison with the GP's that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. The service had a gastrointestinal outbreak contained within the special care unit in April 2015. A review of outbreak documentation including the staff debrief indicated that the outbreak was well managed.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a restraint policy in place that states the organisations philosophy to restraint minimisation. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. On the day of audit there were three residents with restraint and two residents with enablers. Residents using enablers have voluntarily signed a consent form. Assessments are completed and enabler use is reviewed six monthly by the restraint coordinator (clinical manager) and Approval Committee.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>Three restraint files were reviewed. Each file had a separate care plan for the use of restraint. The form of restraint used was identified in the resident restraint care plan. Restraint monitoring forms were sighted for each of the three residents. Monitoring forms identified the form of restraint, frequency of monitoring, time on and off for restraint and cares delivered during the period of restraint. The previous shortfall around restraint care plans and monitoring forms has been addressed.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Policies and procedures are in place to ensure all residents have appropriate and timely assessments and interventions undertaken.</p> <p>In six permanent resident files sampled the long term care plan reflected interventions required to meet the resident's current needs. Short term care plans were in place for short term needs. Care staff stated they are aware of short term needs for residents and any significant events that require monitoring. Residents (as appropriate) and relatives states the resident's needs are being met and they are kept informed of any health changes.</p>	<p>One (private) hospital respite resident did not have a post falls protocol for an unwitnessed fall as per the organisational falls protocol, and an accurate fluid input chart for enteral feeding had not been maintained.</p>	<p>Ensure interventions are completed as documented in care plans and medical notes.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.