

# Lonsdale 2005 Limited

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## 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:

<b>Legal entity:</b>	Lonsdale 2005 Limited
<b>Premises audited:</b>	Lonsdale Total Care Centre  Riverside Lodge
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 21 October 2015      End date: 22 October 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	54

# Executive summary of the audit

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## 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

Lonsdale Total care and Riverside Lodge rest home are privately owned. Lonsdale provides rest home, hospital and dementia levels of care for up to 50 residents and Riverside Lodge provides rest home care to up to 20 residents. On the day of audit, there were 54 residents – 38 residents at Lonsdale and 16 residents at Riverside. The general manager/registered nurse is responsible for the daily operations of the two facilities. A general manager/registered nurse for the on-site education centre and a household manager support him.

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, general practitioner, management and staff.

Environmental improvements under construction on the day of audit are a new kitchen, nurses' station, and two single rooms with ensuites and additional lounge in the hospital area.

One of two previous certification shortfalls around medication reviews has been addressed. Further improvements are required in relation to documented interventions.

This audit identified an improvement required around care plan timeframes.

The service has been awarded a continuous improvement around Vitamin D usage and falls prevention.

## 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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There is an open disclosure policy, which describes ways that information is provided to residents and families/next of kin at entry to the service. Family are involved in care planning, and receive and provide ongoing feedback. A system for managing complaints is in place and there is evidence of follow-up. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Staff interviews confirmed an understanding of the complaints process.

## 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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The organisation has an annual business and quality plan in place with annual quality objectives. Quality information is reported to monthly staff/quality meetings, weekly management meetings and to the CEO. The service is actively involved in ongoing quality projects to improve outcomes and service delivery for the residents. The service has comprehensive policies/procedures to provide rest home, hospital and dementia level of care. There are documented job descriptions for all positions, which detail each position's responsibilities, accountabilities and authorities. A staffing policy includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a documented in-service annual programme for education/training.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurse is responsible for each stage of the provision of care. Residents and family interviewed state they are involved in the care planning process. InterRAI assessments and evaluations are developed within the required timeframe or earlier as required due to health changes. Resident files include notes by the general practitioner and allied health professionals.

Medication policies and procedures are in place to guide practice. All staff responsible for administration of medicines completed education and medication competencies. The electronic medication charts reviewed include documentation of allergies and intolerances.

There are separate activity programmes for the rest home, hospital and dementia care residents, which are resident-focused and provide a variety of activities including entertainment and outings to meet the interests and abilities of the resident group. Community links are maintained.

All meals and baking is prepared and cooked on site. Residents' nutritional needs have been identified and choices accommodated. A dietitian reviews the menu. There are nutritious snacks available over 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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Lonsdale total care and Riverside rest home have a current building warrant of fitness.

## 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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The service has policies and procedures to appropriately guide staff around consent processes and the use of enablers. A registered nurse is the restraint coordinator. There are currently no residents using enablers and eight residents using restraint. Staff receive training in restraint and managing challenging behaviour.

## 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 and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinators (registered nurse) are responsible for the collation of infections. There are policies and guidelines in place for the definition and surveillance of infections. The infection control coordinators use the information obtained through surveillance to determine infection control activities and education needs within the facility.

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	13	0	2	1	0	0
<b>Criteria</b>	1	35	0	2	1	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 service has a complaints policy and procedure in place that aligns with the Code of Rights. A complaints procedure is provided to residents within the information pack at entry. There is a current complaints register. Compliments/complaints forms are readily available. There is evidence that three verbal complaints and seven written complaints received in 2015 have been addressed. Outcomes of the complaints are discussed at the CEO/management meetings and staff meetings as appropriate.</p> <p>Discussion with five residents (four rest home and one hospital level of care) and relatives, confirmed they were provided with information on the complaints process and are comfortable approaching management with any concerns/complaints. Staff interviewed confirmed that concerns/complaints were discussed at monthly staff/quality meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families and the management team promotes this. The information pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry and any items they have to pay for that is not covered by the agreement. Residents receive quarterly newsletters that keep them informed on all matters that affect them, community news and facility renovations. The information pack is available in large print and advised that this can be read to residents. Interpreter services are available as required.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Eight relatives (four rest home, two hospital and two dementia level) interviewed, stated that they are informed when their family member's health status changes. Discussions with health care assistants (HCA) and registered nurses (RN) identified their knowledge around open disclosure. There are resident meetings held quarterly at both sites with the opportunity for feedback on the services.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Lonsdale total care is a 50-bed facility that provides rest home, hospital/medical and dementia level care. Occupancy on the day of audit was 38 residents (nine of 12 rest home residents, 19 of 26 hospital residents and 10 residents in the 12-bed dementia unit). Riverside lodge is a 20-bed rest home. The total number of residents at Riverside on the days of audit was 16 residents.</p> <p>A general manager, who has been in the role since October 2014, manages the two facilities. The general manager also covers the clinical manager role, a position he held before becoming the general manager. The general manager had experience in education and business prior to becoming a registered nurse (RN) including five years' experience working at the DHB in an over 65 year's surgical ward. The household manager and office manager manages non-clinical services. The general manager has maintained at least eight hours of professional development annually including palliative care modules, attending relevant courses and forums provided at the DHB.</p> <p>The CEO (owner) meets monthly with the general manager, general manager of the education centre, household manager and office manager. The 2015 – 2016 annual business/quality plan has been developed. The business/quality plan clearly identifies the purpose, scope, values and direction of the organisation. Key clinical goals are indicated in the plan around falls prevention, InterRAI and care planning, medication management and supporting technology. Management meeting minutes sighted evidenced regular reviews of the 2015 – 2016 annual business/quality plan.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>FA</p>	<p>There are organisational policies to guide the facility to implement the quality management programme including (but not limited to) quality assurance and risk management programme, management responsibilities, health and safety and infection control responsibilities and internal audit schedule. Quality information is discussed at the monthly staff meetings and weekly management meetings. Staff interviewed stated they are well informed and receive quality and risk management information such as accident/incident stats and infection control stats. Reports are provided from the health and safety representatives and infection control coordinators to the CEO/management meeting. The HCAs interviewed speak highly of the management team and state they are asked for suggestions and feedback on quality initiatives. An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed. A quality and risk management programme is in place that includes health and safety and</p>

<p>continuous quality improvement principles.</p>		<p>hazard identification. Staff report any hazards identified on the daily maintenance request/hazard form.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and accidents and any areas for improvement. Identification of interventions is made on a case-by-case basis to minimise future falls. Prevention strategies and corrective actions are documented in the residents care plan. The service has attained a continuous improvement rating for falls reduction and Vitamin D usage.</p> <p>Surveys completed annually are residents/relatives (July 2015), food survey (August 2015) and staff survey (July 2015). The survey results are collated to identify if there are any areas for improvement.</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>There is an accident/incident policy, which is part of the risk management plan. Monthly data collection of accident/incidents is completed. When an incident occurs the staff member discovering the incident completes the accident/incident form. The incident/accident is documented in the progress notes. The RN on duty completes a clinical assessment and identifies preventative and corrective actions. All incidents/accidents are signed off by the general manager, who conducts a further investigation if required. Fourteen incident forms sampled evidence detailed investigations and corrective action plans following incidents, including neurological observations for four of the resident related incidents.</p>
<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</p>	<p>FA</p>	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (one general manager, two HCAs, one diversional therapist, one RN, one cook). The recruitment and staff selection process requires that police vetting and reference checks are completed prior to employment to validate the individual's qualifications, experience and suitability for the role. All files evidence a signed job description. There is an orientation programme in place, which has been reviewed and a new programme introduced in January 2015. Staff are orientated to their area of work and complete competencies relevant to their role. Staff files reviewed had annual performance appraisals completed where due. There is a documented annual education/training programme. There are monthly mandatory core training days that cover compulsory requirements. Competencies are identified and completed. Staff responsible for medication administration, complete annual competencies and attend annual education sessions. Registered nurses and HCAs are encouraged and supported to undertake external education. At least eight hours of staff development or</p>

legislation.		in-service education has been provided annually. Four HCAs employed in the dementia unit have completed the required 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	Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs on different shifts. The Lonsdale staffing in the rest home/hospital/dementia unit is as follows; two RNs on morning duty; one RN on afternoon and night shift, six HCAs on morning shift, five HCAs on afternoon and two HCAs on night shift. Riverside has an RN on duty from Monday to Friday and a HCA on duty for the morning, afternoon and night shift. The morning duty RN at Lonsdale is the on-call RN. Staff at Riverside access the RN at Lonsdale after hours for advice and the on-call RN if a clinical assessment is required. The general manager/clinical manager (RN) covers both facilities and works fulltime. Residents and relatives interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent, respectful and friendly.
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.	FA	Medicine management meets legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The service uses an online electronic medication system (with an offline backup) introduced in March 2015. Medications are checked on delivery against the medication chart. Standing orders are not used. There were no self-medicating residents on the days of audit.  Ten electronic medication charts were sampled. All charts had photo identification and allergy status identified. All ten medication charts have been reviewed by the GP at least three monthly. The service has addressed this previous finding.
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	FA	There are policies/procedures for food services and menu planning appropriate for this type of service. A qualified household manager oversees the Lonsdale and Riverside food service. The menu is four weekly rotating summer and winter. A qualified dietitian reviews this twice a year and reports back and any recommendations are actioned. The RN provides the cook with a resident's dietary profile on admission and informs the cook if there are any dietary changes. Resident likes and dislikes are known with alternatives offered. A nutrition and dietetic assessment is undertaken for each resident on admission and includes special dietary requirements. Referrals to the dietitian are made as required. Both facility kitchens are well equipped. Fridge and freezer temperatures are recorded daily. All perishable goods in the fridges are date labelled. Staff were observed wearing correct protective wear, hats, aprons and gloves. Cleaning schedules are in place and are well maintained. There are chemical data sheets available. Chemicals are stored safely at both kitchens. All staff have received food safety and hygiene training. Relatives

<p>component of service delivery.</p>		<p>and residents interviewed expressed satisfaction with food services. An internal kitchen audit is completed as part of the annual audit schedule.</p> <p>There are nutritious snacks available 24 hours in the dementia unit.</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 Moderate</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP consultation or referral to the appropriate allied health professional.</p> <p>Continence products are available and resident files include a urinary continence assessment (where applicable), bowel management, and continence products identified for day and night use. Specialist continence advice is available as needed and the RN on duty could describe the referral process.</p> <p>There were wound management plans and ongoing evaluations for current wounds (link 1.3.3). The wound care plans record the required frequency of dressing changes. The service has addressed this aspect of the previous finding.</p> <p>Documented interventions were sighted for the management of diabetes. There were neurological monitoring observations completed following unwitnessed falls. The service has addressed this aspect of the previous finding.</p> <p>Documented interventions were not completed for all care issues including weight loss, altered mood, pain and behaviours. The previous finding around pain assessments remains. There was evidence of individual monitoring of challenging behaviour on behaviour charts and in the progress notes. Medical notes identify the GP monitors the use of 'as required' medications for behaviours that have not been able to be redirected with activities and de-escalation techniques.</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>PA Low</p>	<p>The service employs a qualified and registered diversional therapist (DT) for 30 hours per week (Monday to Friday) across both facilities. The DT is actively involved in the regional DT group. There are separate activity programmes for the rest home at Lonsdale and Riverside), hospital and residents with dementia. The activities are open to all residents to attend. Activities were observed to occur in all areas of the facilities on the days of audit. Activities are appropriate and meaningful for the residents. There are resources available for staff to use after hours and at the weekends. There are 40 volunteers involved in activities such as games, bowls, card groups, reading, visiting dog, church groups, drives and entertainment. There are two vans available for weekly outings. The service maintains close links with community groups such as RSA, college students, library, inter-rest home activities, combined rest home mystery tours and memory walks for Alzheimer's society.</p> <p>Three monthly resident and family meetings provide an opportunity for feedback on the activity programme.</p> <p>The DT completes an activity assessment and an activity plan, that is reviewed six monthly.</p>

		Resident/family meetings provide an opportunity for feedback and suggestions on the activity programme.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The initial care plans have been evaluated in the sample of files reviewed. The long-term care plan had been developed within three weeks of admission for four of six resident files reviewed (link 1.3.3.3). Written evaluation of long-term care plans are six monthly or earlier as required. There is a physical examination and medication review completed at least three monthly or earlier as required for changes to resident health. The resident (as appropriate) and family confirm they are involved in the care-plan review process. Short-term care plans sighted were evaluated and resolved within a timely manner. Ongoing problems were transferred to the long-term care plan.</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 Lonsdale total care building holds a current warrant of fitness, which expires 31 March 2016. The Riverside Lodge building of warrant of fitness expires 26 November 2015.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection-control coordinator's role is shared between two RNs (Lonsdale and Riverside). Surveillance data is collated monthly and the information is used to determine infection control activities and education needs in the facility. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is reported to the management and staff meetings. Staff interviewed confirmed that infection control and surveillance data is available and discussed at staff meetings.</p> <p>The service had an outbreak in January 2015. Appropriate personnel were notified. Both infection control coordinators have attended external training on outbreak management.</p>
<p>Standard 2.1.1: Restraint</p>	FA	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy (reviewed August 2015) includes restraint procedures. The policy identifies that restraint is used as a last</p>

<p>minimisation Services demonstrate that the use of restraint is actively minimised.</p>		<p>resort. There were no residents with enablers and eight residents with restraints in use. An RN is the restraint coordinator. Staff have received training in restraint and challenging behaviour.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.3 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	Six resident files were reviewed. Initial assessments were completed within the required timeframes. Four of six resident long-term care plans were developed within the three-week timeframe.	Two resident files (one hospital and one rest home) did not have the long-term care plan developed with the required timeframe.	Ensure long-term care plans are developed within three weeks.  60 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>	<p>PA Moderate</p>	<p>Progress notes record significant events and interventions. Family and residents interviewed confirmed they are notified of any changes to the resident's health. There are monitoring forms available for monthly weight, behaviour charts and pain monitoring. Short-term care plans were sighted for short-term needs. Two of six resident files reviewed evidence that interventions are detailed and are consistent with assessments conducted and with changes to health.</p>	<p>i) One dementia resident had not had a behaviour assessment completed. ii) One dementia resident with identified weight loss did not have interventions documented and did not have a 24 hour behaviour management plan documented. iii) One hospital resident with altered mood/behaviour did not have interventions recorded in the long-term care plan. iv) One rest home resident did not have a pain assessment completed and interventions were not documented for identified pain and breakthrough pain. This resident also did not have documented interventions for management of leg oedema as per GP medical notes.</p>	<p>i)-iv) Ensure that assessments are completed and that documented interventions are in place for residents with identified care issues.</p> <p>60 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>A life history is completed by the resident/family describing their past and recent interests, hobbies and community links. Activity plans were in place for the five residents reviewed. The activity plans reviewed were appropriate to their needs, abilities, skills, interests and cognitive function and had been reviewed by the DT six-monthly, however these were not reviewed at the same time as the care plan.</p>	<p>ARC D16.5ciii: Five of the five activity plans had not been reviewed at the same time as the care plan</p>	<p>Ensure that activity plans are reviewed at the same time as the care plan</p> <p>180 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service</p>	CI	<p>The service identified there were increased numbers of mobile residents at risk of falls and falls with injury who were not on the Vitamin D programme, as recommended by the district health board (DHB). The service initiated a falls prevention programme to reduce the number of falls across the three levels of care. The local health centre was established in May 2014 and it provides continuity of care for residents and improved communication with the</p>	<p>The service collated falls, falls with injury and residents on Vitamin D over a 12-month period from March 2014 to March 2015. Over 50% of residents were not on Vitamin D. In March 2015, the service launched a project to reduce falls and increase residents on Vitamin D to meet or exceed the DHB target rate of 75% uptake of residents on Vitamin D. Key staff attended the DHB falls prevention education forum and all staff received education and awareness training on the “five essentials of falls prevention”. Posters are displayed in both facilities and care staff interviewed were able to describe strategies around falls prevention. Care plans for residents at risk of falls documented fall prevention strategies, which were observed to be in practice on the day of audit including use of sensor mats, beds at low height, and minutes of regular team talks around falls data and progress on falls prevention. One staff member is allocated in each unit to monitor residents at risk of falls. Discussions were held with the GPs who assessed each residents risk and prescribed Vitamin D accordingly.</p> <p>Data since March 2015 shows a reduction in the total number of falls</p>

<p>provision is developed and implemented.</p>		<p>provider.</p>	<p>from an average of 13 per month to an average of eight per month. The usage of Vitamin D at Lonsdale and Riverside facilities has increased to exceed the DHB target of 60% of all residents on Vitamin D. At Riverside where residents are mostly mobile and at risk of falls there are 80% of residents on Vitamin D. Where residents are not on Vitamin D, the GP has documented the rationale for this. All Vitamin D usage is reviewed three monthly by the GP.</p>
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End of the report.