# Dixon House Trust Board

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Dixon House Trust Board

**Premises audited:** Dixon House Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 2 November 2015 End date: 3 November 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:** 40

# 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 |
|  | 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

Dixon House is owned and operated by the Greymouth Combined Churches Community Trust Board. The service is certified to provide rest home level care for up to 41 residents with 40 residents accommodated on the days of audit. The facility manager is a registered nurse who has been in the role for four years. An external quality consultant, the board secretary, a quality manager, registered and enrolled nurses and care staff support her. Family and residents interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a subset of the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, general practitioner, staff and management.

The service has addressed nine of the 11 previous certification audit findings relating to recording of communication with families, reporting all adverse events and maintaining incident records, signing and dating of all records, implementation of interventions, displaying a current building warrant of fitness, ensuring fire drills are conducted six monthly, and aspects of restraint documentation and monitoring.

Further improvements are still required in respect to aspects of care planning and medication management.

This surveillance audit identified that no additional improvements are required.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Communication with residents and families is appropriately managed and recorded. Complaints are actioned and include documented response to complainants should the need arise. There is a complaints register.

## Organisational management

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

An implemented quality and risk programme involves the resident on admission to the service. A business plan, quality assurance and risk management plan is being implemented for 2015. Policies and procedures have been reviewed to reflect the activities of the service and align with current guidelines and legislation. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through, following internal audits and feedback from residents and staff. Feedback is sought from residents and families. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are appropriately managed with reporting to staff evident in meeting minutes reviewed. A comprehensive orientation programme provides new staff with relevant information for safe work practice. Human resource policies are in place to determine staffing levels and skill mixes. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are stored and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Kitchen staff are trained in food safety.

## Safe and appropriate environment

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

The service displays a current building warrant of fitness, which expires on 1 June 2016.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There are no residents requiring restraint or enablers.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Infection rates are low and no outbreaks have been reported.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 20 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 43 | 0 | 1 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. 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 available. No complaints have been received in the past two years. Residents and family members advised that they are aware of the complaints procedure and how to access forms. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Six residents and two family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Communication with family members is recorded on the sample of incident and accident report forms reviewed and in the resident daily progress notes. The service has addressed this previous audit finding. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter services are provided if residents or family/whānau have difficulty with written or spoken English.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Dixon House is owned and operated by a combined churches charitable trust. The Dixon House manager reports monthly to the trust board. The manager is a registered nurse and has been in the role for four years. Dixon House is certified to provide rest home level care to 41 residents with 40 residents accommodated on the day of audit, including one respite resident.The service is also contracted by the local DHB to provide care for up to six residents with diagnoses of dementia. There are currently four residents under this contract at Dixon House. These residents are assessed as rest home level care with DHB funding for extra care staff hours. This includes one to one staffing provided for these four residents during the afternoon/evening period. The Dixon House trust board has a constitution for organisational governance and direction with a business plan in place. The service has a quality management system with associated policies and procedures in place and accesses assistance from an external consultant for advice and support. There is a quality and risk management plan in place. The quality plan includes objectives, policies and procedures, implementation, monitoring, quality risk, and action plan. The facility manager has maintained at least eight hours of professional development in the past 12 months.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has an established quality and risk system that includes analysis of incidents, infections and complaints, internal audits and feedback from the residents. Dixon House monitors progress with the quality and risk management plan through quality meetings and staff meetings.There is an internal audit schedule, which is being implemented for 2015. Areas of non-compliance identified through quality activities are documented as corrective actions, implemented and reviewed for effectiveness. The service has a health and safety management system. 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 which have been reviewed. Policies and procedures align with the resident care plans and have been updated to include InterRAI requirements. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow up where required. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The recent 2015 survey of resident and families evidenced 98% overall satisfaction with the care and services provided. |
| 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 is collected and analysed and reported to staff. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for August and September 2015 were reviewed and evidence that all adverse events are documented to manage risk. Appropriate care and support has been provided by care staff and registered nurses post incident and this is well recorded on the reports reviewed and in the corresponding resident files. There have been no pressure injuries sustained by residents since the previous audit. The service has addressed this previous audit finding. Reports were completed and family notified as appropriate. Incidents and accident data is communicated to staff as evidenced in meeting minutes reviewed and staff interviews. The manager is aware of her responsibilities to notify appropriate authorities when required.  |
| 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 are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed and included all appropriate documentation. The service has an 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. Annual appraisals have been conducted for all staff. There is an in-service programme being implemented for 2015, which exceeds eight hours annually. The manager and registered nurses have attended external training including conferences, seminars and sessions provided by the local DHB.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Dixon House rest home has a four weekly roster in place, which ensures that there is at least one staff member on duty at all times and one registered nurse on-call. The manager works full time. The service employs part-time registered nurses and enrolled nurses. After-hours on-call cover is shared between the registered nurses. Caregivers and residents interviewed advised that sufficient staff are rostered on for each shift. All care staff are trained in first aid. Residents and families interviewed advised that there are sufficient staff on duty to provide the care and support required.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The previous certification audit identified that not all resident file documents were signed and dated. Five resident files and associated documentation evidenced that all forms were signed and dated by the person completing the form, including entries in progress notes. The service has addressed this previous finding.  |
| 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 | The service uses individualised medication packs that are checked-in on delivery. A registered nurse and caregiver were observed administering medications and followed the correct process including administration of out of normal times medications. The service has addressed these aspects of the previous finding. Registered nurses, enrolled nurses and senior caregivers are responsible for administering medications and have been assessed as competent to do so. Medication management training has been provided. Medications and associated documentation were stored safely and securely. Medication reviews have not been conducted three monthly by a general practitioner (GP) for all residents as per the medication charts reviewed. Resident photos are current and documented allergies are recorded on all 10 medication charts reviewed. Medications are stored and administered in line with accepted guidelines and legislation. Checking of the controlled drug register has not been routinely conducted as required. There is a self-medicating resident’s policy and procedures in place. There were no residents self-administering medications. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. Not all medication charts reviewed record an indication for use for as required medications. This aspect of the previous finding remains an improvement. All medication orders were signed individually by the GP.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals at Dixon House are prepared and cooked on site. The kitchen is able to cater comfortably for all residents in the rest home. There is a winter and summer menu, which has been reviewed by a dietitian. Meals are prepared in an equipped kitchen adjacent to the rest home dining room and served directly to the residents. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required. Resident dietary profiles, and likes and dislikes are known and any changes are communicated to the kitchen. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required. Resident surveys are conducted which provides a formal opportunity for resident feedback on food services. Residents and family members interviewed indicated satisfaction with the food service. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Files reviewed demonstrated that care plans were individualised. Care plans demonstrate service integration and input from allied health. Activities assessments, care plans and progress notes were reviewed for four permanent resident files and these were up to date. This aspect of the previous audit finding has been addressed. The service has not utilised short-term care plans for all short-term care issues. The sample of long-term care plans reviewed evidence that not all interventions have been documented for all assessed needs and support. These include one resident with behaviour issues, weight loss and the introduction of a new medication (link tracer #1.3.3.3). These aspects of the previous finding continue to require improvement.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Long-term (four of five residents) and initial (one respite resident) care plans are current in the sample of files reviewed, and interventions reflect the assessments conducted with exceptions (link #1.3.5.2). Care plan interventions recorded were detailed, personalised and specific to residents’ medical and nursing needs. Interviews with the registered nurses and caregivers and residents evidence residents input. Dressing supplies are available and adequately stocked for use. Documentation for wound assessment, treatment, frequency of dressings and evaluations is available. There were eight residents with minor wounds including skin tears, fungal nail, cracked heels and keratosis. One resident has a chronic leg ulcer and there were no pressure injuries. The registered nurses interviewed advised that they have access to external wound support via the local DHB as required. Specialist continence advice was available as needed and this could be described. Monitoring forms in place include (but not limited to) weight, blood pressure and pulse, food and fluid charts and blood sugar levels. Monthly weight monitoring is conducted for all residents or more frequently as required as evidenced in the files reviewed. The service has addressed this previous finding.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 diversional therapist provides an activities programme over four days each week with care staff providing activities over Friday, Saturday and Sunday. Activities are planned for the day in conjunction with residents. Planned activities are supported by volunteers from the community (eg, church services). An activity plan is developed for each individual resident based on the resident’s social history and assessed needs (part of the InterRAI assessment). The activity plans were reviewed at the same time as the care plans in resident files sampled. Residents were encouraged to join in activities that were appropriate and meaningful and to participate in community activities. The service has a van used for weekly outings. Residents were observed participating in activities on the day of the audit. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations were comprehensive as evidenced in the sample of files reviewed, and reflect changes to the care plan after evaluations were completed (six monthly). Short-term care plans have been utilised for residents with exceptions (link #1.3.5.2). Any changes to the long-term care plan are dated and signed. The RN had evaluated initial care plans sighted, within three weeks of admission. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Dixon House rest home displays a current building warrant of fitness, which expires on 1 July 2016. The service has addressed this previous finding.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The previous audit identified that fire training had not been conducted six monthly. Training records were reviewed and evidenced that six monthly fire evacuation drills have been conducted, and staff have received training in emergency management. The service has addressed this previous finding.  |
| Standard 3.5: SurveillanceSurveillance 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 the infection prevention and control policy. Monthly infection data is collected for all infections, based on signs and symptoms of infection. An enrolled nurse and a registered nurse responsible for the quality programme share the role of infection control nurse. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually. Infection control education has been provided in 2015. No outbreaks have been reported. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Documented systems are in place to ensure the use of restraint is actively minimised. The facility was not utilising restraint or enabler use on audit day. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Enablers are voluntary. Restraint use is reviewed via quality and clinical staff meetings, and education and audits have been completed. |
| Standard 2.2.1: Restraint approval and processesServices 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 previous audit identified that one resident had been on restraint and that the GP had not been part of the approval process. The service now does not have any residents on restraint. The service has addressed this previous finding. |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The previous audit identified that one resident had been on restraint and that restraint assessment documentation had not been completed. The service now does not have any residents on restraint. The service has addressed this previous finding. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | The previous audit identified that one resident had been on restraint and that each episode of restraint had not been monitored or recorded. The service now does not have any residents on restraint. The service has addressed this previous finding. |

# 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 1.3.12.1A 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 | Ten medication charts were reviewed. All charts have the resident’s current photograph and allergies recorded. Administration signing sheets were correctly completed. The manager and registered nurses advised that they have actively been encouraging the GPs to complete the required three monthly reviews of residents, and to complete all documentation as required. Six of 10 medication charts evidence three monthly reviews completed by the GPs. One resident is on respite. Indications for use are recorded for seven of 10 charts reviewed. Advised that controlled drug checks are to be conducted weekly, however, gaps were identified in the timeframes for required checks. The local pharmacist has completed six monthly stock takes. | i) Medication reviews have not been conducted three monthly by the GPs for three of 10 residents; ii) indications for use have not been recorded for ‘as required’ medications for three of 10 residents charts; iii) weekly controlled drug register checks have not been routinely conducted.  | i) Provide evidence that three monthly medication reviews are conducted for all residents; ii) ensure that medication orders for ‘as required’ medications include the indications for use; iii) provide evidence that weekly controlled drug register checks are conducted. 60 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The long-term care plans in place for three of four permanent resident files reviewed include interventions based on assessments. The InterRAI assessment tool has been utilised and forms the basis of the long-term care plan. Short-term care plans were in use for infections, wounds and one resident with previous weight loss.  | One resident has challenging behaviours, weight loss and has had a new medication introduced. The resident file did not evidence that a behaviour assessment had been conducted and interventions for managing the challenging behaviours have not been recorded in the long-term care plan. Short-term care plans have not been utilised for the recent weight loss or commencement of a mood stabilising medication.  | Ensure that care plans describe the interventions required to meet resident needs based on completed assessments and that interventions to manage short-term needs are documented on short-term care plans. 30 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.