# Beetham HealthCare 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](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:** Beetham HealthCare Limited

**Premises audited:** Beetham HealthCare

**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 January 2016 End date: 20 January 2016

**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:** 42

# 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

Beetham Health Care is a modern purpose built facility. The business is privately and locally owned. The facility is divided into 36 hospital/rest home bed units and a six bed dementia care unit. Occupancy on the day of audit was 20 rest home residents, 16 hospital residents and six dementia care residents. The general manager has a significant amount of experience in the aged care environment. Relatives and residents interviewed spoke positively about the service provided.

The audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident’s and staff files, observations and interviews with relatives, staff and management.

The service has addressed three of six previous audit findings relating to complaints documentation, human resource processes, and medication documentation. Further improvements are required around care planning, interventions and evaluations.

This audit has also identified improvements required relating to internal audit follow up, registered nurse supervision of the dementia unit, and activities in the dementia unit.

## 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. |

There is evidence that residents and family are kept informed. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

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

Beetham Health Care has a quality and risk management system to supports the provision of clinical care. Components of the quality management system are discussed at the monthly staff and quality meetings. This includes a summary of incidents, infections and internal audit results. Six monthly resident and family satisfaction surveys are completed and there are two monthly resident and family meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. Staffing policy aligns with contractual requirements and includes 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 medium or high risk and/or unattained and of low risk. |

The registered nurses are responsible for care plan development with input from family. Relatives interviewed confirmed that the care plans are consistent with meeting residents' needs. Residents and families advised satisfaction with the activities programme. Medications are prescribed and administered in line with recognised guidelines and regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met

## 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. |

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

## 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. |

There is a philosophy to actively minimise the use of restraint. There is a restraint policy that includes comprehensive restraint procedures and aligns with the standards. There was one resident with restraint and 12 residents with 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. |

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 12 | 0 | 2 | 3 | 0 | 0 |
| **Criteria** | 0 | 35 | 0 | 2 | 3 | 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](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).

|  |  |  |
| --- | --- | --- |
| **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 that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Care staff interviewed were able to describe the process around reporting complaints.  There is a complaints register. Twelve complaints lodged on the complaints registered for 2015 were reviewed. The complaints reviewed have been managed appropriately with acknowledgement, investigations and responses recorded. The previous audit finding has now been addressed. Residents and family members advised that they are aware of the complaints procedure and how to access forms. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Five residents (three rest home and two hospital) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incidents and the requirements of full and frank open disclosure. Incident/accident forms reviewed evidenced that families were notified following an adverse event. Five relatives interviewed (two rest home level, three hospital level) confirmed they were notified of any changes in their family member’s health status. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Beetham Health Care is a modern purpose built facility. The business is privately and locally owned. The facility is divided into 36 hospital/rest home bed units and a six bed dementia care unit. Occupancy on the day of audit was 20 rest home residents, 16 hospital residents and six dementia care residents. There were no respite residents and no residents under the medical component. All residents were under the age related contract.  The general manager has been in the role since September 2014 and has a significant amount of experience in the aged care environment. She is supported by a quality coordinator (also a registered nurse) has been in the role since May 2014. The clinical nurse manager (RN) started in the role in July 2014 and is also experienced in aged care.  A strategic business plan (2015 to 2018) is in place, which the general manager reports is a working document that is regularly updated by the directors. Five key strategic goals are included in the strategic plan as follows financial and budget, improvement and quality assurance, achieving excellence in service, providing high quality of life for the residents and integrated services for Beetham Health Care and Beetham Lifestyle Village. There are timeframes and responsibilities for each goal. The strategic plans are signed off by the board of three directors.  The general manager has completed a minimum of eight hours of professional development relating to the management of an aged care service in the past 12 months. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There is a quality and risk management plan in place, which covers policies and procedures, audits, infection control surveillance, complaints, human resources, customer feedback, incident reporting, restraint register, regular multidisciplinary client review, health and safety, training and education programmes and service improvements. There are weekly management meetings and monthly quality meetings. The general manager provides a financial and monthly report to the board of directors. The service has annual quality goals which are reviewed (sighted). Quality goals are set with specific aims, responsibility and sign off as achieved.  Policies are in place for all aspects of the service. All policies are subject to a minimum of two yearly reviews. Policies are readily available to staff in hard copy. Electronic versions of policies are also available. A document management process controls policies and procedures. The review process is overseen by the quality coordinator and policies are up to date.  There is an internal audit programme (schedule) that monitors key aspects of the service, however, not all audits have been completed as per the schedule. Corrective action plans have been developed and documented, where opportunities for improvements have been identified. Not all corrective actions reviewed have been signed off as completed. Audit results are provided in the monthly quality meetings with evidence of discussions relating to any identified corrective actions (quality meeting minutes sighted). All staff interviewed report they are kept informed of quality improvements and corrective action plans. |
| 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 | There is an incident policy and monthly tracking that is taken to staff, quality and health and safety meetings. A record of the incident is recorded in the resident progress notes. All incident/accident forms reviewed were completed appropriately and in a comprehensive manner. The registered nurse (RN) is involved in clinical assessment for all incidents. There are documented actions and preventative or corrective actions completed on the resident related incident/accident form (link to 1.3.8.2 for service supervision following an incident). The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service.  The general 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 are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.  Five staff files were reviewed (quality coordinator, clinical nurse manager, caregiver, and cook and activity coordinator). Qualifications of applicants are validated and police vetting is completed prior to appointment. Staff undergo a generic orientation including health and safety, fire training and infection control education. Staff also complete a specific orientation to their role. All five files evidence completed orientation records. The previous audit finding has now been addressed.  The organisation has an annual education programme with sessions held every month. The quality coordinator, clinical nurse manager, general manager, registered nurses, physiotherapist and external educators provide education and training for staff. The education programme includes mandatory training and clinical in-service relevant to the care of the residents. The quality coordinator is the service Career force assessor. RNs are supported to attend knowledge and skills based education. Registered nurses and the activity coordinator have a current first aid certificate.  There are four caregivers who work in the dementia unit. Three caregivers have completed their NZQA dementia certificates. One staff member has yet to commence the training and has been employed for less than one year. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy in place. Advised by the general manager and clinical nurse manager that there are sufficient staff rostered on to meet the needs of the residents.  The general manager, clinical nurse manager (RN) and quality coordinator (RN) are employed full-time Monday to Friday. There is one RN on duty 24/7. The registered nurse rostered on in the rest home/hospital provides cover for the dementia unit (link 1.3.8.2). There are four caregivers on the full morning shift and one from 7-11am. There are four caregivers on the full afternoon shift and one from 5-9pm. The night shift is staffed in the rest home/hospital with one registered nurses and one caregiver. There is one caregiver in the dementia unit 24/7. Residents and families interviewed advised that there is sufficient staff on duty to provide the care and support required. |
| 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 | There are policies and processes that describe medication management that align with accepted guidelines and this is implemented into practice Medication trolleys are kept in locked treatment room in the rest home/hospital. There is a designated medication fridge. Temperatures are monitored and are within the acceptable range. There are no self-medicating residents. There is weekly physical check evidenced in the controlled drug register signed by the RN and the pharmacy. RNs and designated caregivers complete annual medication competencies and medication education. Ten medication charts sampled (four hospital, two rest home and four dementia) and signing sheets sampled identified all medication charts had photo identification and allergies/adverse reactions noted. The previous audit findings around medication management and documentation have all been addressed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There are food policies/procedures for food services and menu planning appropriate for this type of service. There is a qualified chef who oversees food services, ordering of food items and staffing. The menu is a five week rotating summer and winter. This is reviewed by a qualified dietitian two yearly. Resident likes and dislikes are known with alternative choices offered. There are specialised lip plates and utensils as required to promote resident independence at meal times. The kitchen is well equipped with adequate pantry and dry good storage space. A nutrition assessment is undertaken for each resident on admission. This includes likes and dislikes and special dietary requirements.  The kitchen holds at least three days of food in case of an emergency. Fridge and freezer temperatures are recorded daily and all perishable goods in the fridge are date labelled. All staff have received food safety and hygiene training. Family and residents interviewed expressed satisfaction with food services.  There is evidence of additional nutritious snacks available over 24 hours for the dementia unit. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Care plans are developed and reviewed by the RN’s. The long term care plan is developed within three weeks of admission.  The care plan overall meet the residents needs and includes diagnosis/needs, aim and action. Service delivery plans demonstrate service integration. Short term care plans are in use for changes in health status. Resident files reviewed identified that family were involved. Relatives interviewed confirmed they are involved in the care planning process. The previous audit identified that Maori resident’s do not all have an individual Maori health plan. This is a continued finding for this audit. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Long term care plans (LTCP) are in place for all residents who have been admitted for over three weeks. The LTCPs document interventions consistent with needs identified through interRAI and paper based assessments.  Of the five resident files sampled three had bed rails in use. The care plans did not document the risks associated with their use. The previous audit finding remains. The previous audit identified gaps around diabetes management, resident weight monitoring and resident behaviour management plans. These aspects of the previous finding have been addressed.  Dressing supplies are available and a treatment room is stocked for use.  There were five residents with identified wounds and wound management plans, including one resident with a pressure injury on the day of audit. Not all wound documentation has been fully completed.  Continence products are available and resident files include an admission urinary and bowel continence assessment that is reviewed at least six monthly or earlier if there are any changes in resident continence. Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained.  Specialist continence advice is available as needed and this could be described by the RN's interviewed. .  The dietitian visits monthly and the physio visits as needed. Physio instructions have not been transcribed into the care plans for all residents. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Moderate | The service employs three activity coordinators, two of whom are undertaking diversional therapy qualifications  Activities are provided seven days a week. The activity coordinators provide a monthly programme for rest home/hospital residents with dementia level residents often joining in the activities provided in the rest home and hospital. There is no specific dementia unit activities plan documented. Outings are scheduled using a pre-book bus service. Residents are invited to all activities and functions. A variety of activities are provided including daily exercise, group activities, entertainers and college/school children visit. Resident’s spiritual needs are met with inter-denominational church services weekly. Volunteers are actively involved weekdays and weekends. Resident meetings are held two monthly where residents provide feedback and suggestions on the programme. Residents and family/whanau interviewed are satisfied with the content and variety of the activity programme.  There is an activity assessment for each new resident from which an activity plan is developed. This is evaluated and reviewed every six months. There are activity plans in place for the dementia care unit residents however these are not 24 hour plans. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Care plan reviews are signed as completed by an RN. Short term care plans (STCP) are developed for the management of short term needs. Short term care plans sighted in resident files have not all been evaluated or closed off as resolved. This is previous audit finding has not been fully addressed. Registered nurses interviewed advised that they document monitoring requirements in the progress notes and in short term care plans however, the monitoring of residents is not consistently documented and RN follow up of issues identified are not documented as reviewed / followed up by RNs.  The previous finding around risk assessments has been rectified. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance and monitoring is included in the newly implemented infection control programme. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. All infections are individually logged monthly. The data graphed for trends and evaluated monthly and annually. Infection control review is included as part of the quality meeting. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has a philosophy to actively minimise the use of restraint. There is a restraint policy that includes comprehensive restraint procedures and aligns with the standards. There are twelve residents with enablers (bed rails) and one hospital resident with restraint. Restraint/ enabler usage is a discussion agenda quality meetings. Enablers are voluntary. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Beetham Healthcare have an internal audit programme (schedule) that monitors key aspects of the service. Some audits and corresponding corrective actions have not been fully completed. Corrective action plans are developed and documented, dependant where opportunities for improvements are identified. | The 2015 internal audit schedule has not been fully adhered to. Not all 2015 corrective action plans have been completed and signed off. | Ensure that the internal audit schedule is followed and that all corrective action plans are completed and signed off.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | The service has a Maori Health Plan in place that describes individual cultural assessments for Maori residents that guide staff in the delivery of culturally safe and acceptable care. Not all residents with cultural needs had this addressed within the care plans and activity plans. | Three resident files were reviewed for residents who identify as Maori, one from the dementia unit, and two hospital. The care plans, including activities plans, do not include cultural care and activities specific to Maori needs. | Ensure that residents with identified cultural needs have this documented in their care plans  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Wound care plans are in place for all residents with identified wounds. Five wound care plans were reviewed for this audit including four skin tears and one pressure injury. One resident’s wound care documentation was completed. Three residents with bed rails all have consents and assessments in place and staff interviewed were aware of the need for monitoring. One of three residents with bed rails had this documented in the long term care plan. Physio and other allied health interventions were documented in all but one resident files as needed. | i) Of the five wound care plans reviewed, two did not have changes to the management plan documented, two wound evaluations did not include size of wound or degree of improvement/ deterioration and one wound dressing was not completed according to time frames. The pressure injury wound assessment did not have the grade of pressure injury documented (noting that the injury is healing and is now a grade two); ii) One resident with physio interventions did not have this reflected into their care plan; and iii) two of three residents with bed rails did not have this included in their care plan and three of three did not have the risks associated with bed rails in their care plans. | i) Ensure that wound care plans document the care needed, accurate evaluations of care are recorded and dressings are undertaken according to time frames; ii) Ensure that allied health interventions are reflected into care plans; and iii) ensure that care plans include the use of restraint/ enablers and the risks associated with their use.  30 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | Family and residents interviewed praised the activities programme. On the days of audit a variety of activities were witnessed, with some residents from the dementia unit actively involved in recreation provided in the rest home and hospital area. Staff report that caregivers in the dementia unit and activity staff provide one on one time with the dementia residents and some group activities. | i) There is no dementia specific activity plan in place. On the day of audit no activities were witnessed as occurring in the dementia unit; and ii) The two dementia unit resident files reviewed had an individualised activity plan in place but this was not documented over a 24 hour period and was not orientated to residents with challenging behaviours. | i) Ensure that a dementia specific activity plan is in place and provided for residents in the dementia unit; and ii) ensure all residents in the dementia unit it have an individualised 24 hour activity plan.  60 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | There is evidence of six monthly reviews and evaluation of long term care plans in four of five resident files which are signed by the RN. One resident has been in the service less than six months. | i)A STCP to monitor for pain and swelling is not documented as evaluated or monitored for one wound plan in the dementia unit and one at hospital level; ii) the ongoing monitoring of resident need is not documented one resident in the hospital unit bed rails for restraint; iii) RN review and/ or monitoring of identified issues is not documented for one resident following a fall and a painful leg, one resident following an ‘as needed’ medication in the dementia unit, and one resident at hospital level with a swollen knee. | Ensure that ongoing monitoring and evaluation of care is documented for identified resident issues and plans of care.  60 days |

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

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

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

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

|  |
| --- |
| No data to display |

End of the report.