# Bupa Care Services NZ Limited - Longwood Rest Home

## 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:** Bupa Care Services NZ Limited

**Premises audited:** Longwood Rest Home

**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: 23 February 2016 End date: 23 February 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:** 43

# 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

Bupa Longwood provides rest home and hospital (geriatric and medical) level care for up to 52 residents. On the day of audit there were 43 residents. The service is managed by an experienced care home manager. She is supported by a clinical manager who has been in the role for one year. The residents and relatives interviewed commented positively about the care and support provided.

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. The audit process included the review of policies and procedures, the review of residents’ and staff files, observations, and interviews with residents, family, general practitioner and staff.

No improvements were identified at the previous audit.

This surveillance audit found that improvements are required around data collection, corrective action plans, incident reporting and investigation, registered nurse cover, documentation of behaviours, and evaluations.

## 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. There is a policy to guide staff on the process around open disclosure. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The Bupa strategic and quality plan includes quality goals for 2016. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually.

## 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. |

The sample of residents’ records reviewed provides evidence that the provider has implemented systems to assess and plan the needs of the resident. Care plans demonstrate service integration. Resident files include notes by the GP and allied health professionals. Medication policies and procedures are in place to guide practice. The activities programme is facilitated by an activities co-ordinator and two activity assistants. The activities programme provides varied options and activities are enjoyed by the residents. The programme caters for the individual needs. Community activities are encouraged; van outings are arranged on a regular basis.

All food is cooked on site by the in house cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented.

## 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 building holds a current warrant of fitness.

## 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. |

Restraint minimisation and safe practice policies and procedures are in place. There are seven residents with restraint and one with an enabler. Education has been provided. Policy aligns with the standard and states that enablers are voluntary.

## 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 infection control officer (clinical manager) is responsible for collating monthly infection rates. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Bupa facilities.

## 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 | 11 | 0 | 2 | 3 | 0 | 0 |
| **Criteria** | 0 | 32 | 0 | 4 | 3 | 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 complaints policy and procedures in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Six staff interviewed were aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained with a current complaints register. There have been three complaints recorded for 2015, and none for 2016 to date. All are well documented including investigation, follow up and resolution. Eight residents (one YPD, three hospital, and four rest home) and family members advised that they were 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 | There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Incident reports and associated resident files reviewed met this requirement. Six family members (three rest home and three hospital) interviewed confirmed they were notified following a change of health status of their family member. The care home manager implements an ‘open door’ policy and communication is maintained. There was an interpreter policy and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa Longwood is certified to provide hospital (medical and geriatric) and rest home level care for up to 52 residents. On the day of audit there were 43 residents in total, which included 16 rest home (two rest home respite) and 27 hospital residents (two residents under the age of 65 and three hospital respite residents). All residents are under aged related contracts.  Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Bupa Longwood has set specific quality goals for 2016. Progress with the quality assurance and risk management programme is monitored through the Bupa managers’ meetings and various facility meetings. Monthly and annual reviews are completed for all areas of service.  Bupa has robust quality and risk management systems implemented across its facilities with four benchmarking groups established for rest home, hospital, dementia, and psychogeriatric/mental health services. Longwood is benchmarked in two of these.  The service is managed by an experienced registered nurse (RN) who has been the care home manager at Bupa Longwood for two years and is supported by a clinical manager who has been in this position for over one year. Care home managers and clinical managers attend annual organisational forums and regional forums six monthly. The regional operations manager visits monthly and more often if required. |
| 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 Bupa strategic plan for 2012-2015 which is completed. The new strategic plan for 2016 – 2019 is in draft form and is due for release by the operational management team. There is a quality management programme for Bupa Longwood with risk management plans documented. Goals and objectives for 2016 have been developed for Longwood and the quality plan for 2015 has been reviewed. Quality improvement initiatives for Bupa Longwood have been documented and are developed as a result of feedback from residents and staff, audits, and benchmarking. Not all incidents and accident data has been collated. Meeting minutes evidence discussion around quality data. Staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with staff confirm their involvement in the quality programme. The service has comprehensive policies/ procedures to support service delivery. The policies are reviewed regularly and evidence current best practice. Staff are required to read policies as they are reviewed/amended.  Internal audits have been completed as per schedule for 2015 and for 2016 year to date. Areas of non-compliance identified through quality activities are documented as corrective actions, however not all corrective actions have been implemented and reviewed for effectiveness.  There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff have received training to support falls prevention. The service collects information 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 resident/relative survey conducted in 2015 showed a result of 90% overall satisfaction. |
| 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. | PA Moderate | There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Incident and accident data is collected and analysed and benchmarked through the Bupa benchmarking programme (with exception link #1.2.3.6). A sample of resident related incident reports for January 2016 were reviewed. All reports and corresponding resident files reviewed evidence appropriate and timely clinical care was provided immediately following an incident. Full investigation and follow up by the clinical manager was not evidenced for all reports reviewed. There is documented evidence of family notification following incidents/accidents.  The provider was unaware of their obligations in regards to essential notifications. A reportable event was not notified to the relevant authorities until the day of audit. |
| 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 | There are organisational policies to guide recruitment practices and documented job descriptions for all positions. Appropriate recruitment documentation was seen in the five staff files reviewed (clinical nurse manager, activities coordinator, two caregivers and a registered nurse). A register of practising certificates is maintained. Staff appraisals were completed and current for those staff who were due. Interviews with caregivers confirmed that management are supportive and responsive.  There is an annual training plan that is being implemented. Bupa ensures registered nurses are supported to maintain their professional competency. Education sessions have been held at least monthly. There is an induction programme with completion being monitored and reported monthly to head office as part of the reporting programme. Interviews with staff informed the induction programme meets the requirements of the service. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | There is an organisational staffing policy that aligns includes skill mixes. Bupa Longwood has a four weekly roster in place which ensures there are adequate staffing levels to meet the acuity and safety needs of the residents. There are casual staff and bureau staff available. The care home manager, clinical manager and registered nurses oversee the clinical care of residents. There is a registered nurse rostered on duty each shift, however, not all shifts have been covered by a registered nurse on duty. Registered nurses and caregivers advise that sufficient staff are on duty for each shift. Interviews with residents and relatives confirmed staffing overall was satisfactory. |
| 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 | Bupa has comprehensive medication policies in place. Medication storage and administration follow safe guidelines. Medication reconciliation is completed on admission and the policy includes guidelines on checking medications on admission. All staff administering medication have completed an annual medication competency.  Ten medication charts were reviewed (four rest home, six hospital level). They were legible and meet legislative guidelines. Ten of the ten medication charts sampled have photographic identification. Signing on administration was up to date, including ‘as required’ medications (PRN). All PRN medications had indication for use identified on the medication chart. All medication charts identified any allergies. Eight of ten medication charts reviewed had written evidence of the GP three monthly review (two medication charts were new), or more as conditions changed, all had been signed and dated. All medications prescribed to be administered regularly were signed as being administered regularly. Weekly medication checks were documented. There was one self-medicating resident.  Their file contained a self-medication assessment and was identified in the medication charts signed and dated by the GP. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The national Bupa menus have been audited and approved by an external dietitian. The service employs two cooks and kitchen assistants. Fridge and freezer temperatures are monitored and documented daily in the kitchen. All food containers are labelled in the kitchen. Meals are prepared in the kitchen and delivered to the hospital dining rooms.  There are nutritional assessments and management policy and a weight management policy.  The residents have a nutritional profile developed on admission, which identifies dietary requirements, likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the kitchen manager. Concerns about any resident weight loss are reviewed between the cook and clinical manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets are catered for. |
| 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 | Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans were evident. The use of short term care plans was evident. A resident with considerable challenging behaviours has not had assessment, monitoring and care planning management completed for the behavioural issues. The GP interviewed stated the facility applied changes of care advice immediately and was complimentary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident’s primary care is provided by the facility GP, unless the resident chooses another GP.  Dressing supplies are available and a treatment room is stocked for use.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is a diversional therapist who works in both the rest home and hospital and works six and a half hours a day, four days a week. There is an assistant who works either a Saturday or Monday.  There is a full and varied activities programme in place which is appropriate to the level of participation from residents’. On the day of audit there was an activity event in the rest home lounge and residents in both areas were observed being actively involved in this activity. The programme is developed monthly and displayed in communal areas and resident bedrooms. The diversional therapist stated there was a van trip most days, depending on the weather. Residents and families interviewed voiced their satisfaction for the activities programme and felt that recreational needs were being met.  Residents have an activities assessment completed over the first few weeks. Resident files reviewed identified that the individual activity plan is reviewed six monthly. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | All initial care plans are evaluated by the registered nurses within three weeks of admission. The long term care plan is documented as evaluated at least six monthly or earlier if there is a change in health status. Not all resident goals and changing conditions have been evaluated. There is at least a three monthly review by the GP. All changes in health status are documented and followed up. Care plan reviews are signed by an RN/clinical manager. Short term care plans are evaluated and resolved or added to the long term care plan if the problem is on-going as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| 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 building holds a current warrant of fitness which expires on 1 October 2016. |
| 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 | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The clinical manager is the infection control officer with support from the care home manager. Information obtained through surveillance is used to determine infection control activities, resources, and education needs within the facility. Infection control is discussed as part of the quality management meeting.  Infection control data is collated monthly and reported at the infection control committee meeting and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices, identifying trends and corrective actions/quality initiatives. Infection control data is displayed for staff. The infection control programme is linked with the quality management programme. Monthly data is forwarded to head office where benchmarking occurs against other Bupa facilities. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's who advise and provide feedback /information to the service. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimized. Policies and procedures include definitions of enablers that are congruent with the definition in NZS 8134.0. Enablers are voluntary. There were six hospital residents with restraint (four lapbelts and two bedrails) and two hospital residents with enablers (two bedrails). Restraint is discussed via the quality, infection control and restraint meeting. Training has been provided around restraint minimisation, enablers and de-escalation techniques. The care home manager is the designated restraint coordinator. One enabler file reviewed evidenced that the required documentation was completed. |

# 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.

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| **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 | Quality activities are conducted at Bupa Longwood. Internal audits are completed. Incidents and accidents are part of data collated including (but not limited to) falls, skin tears, pressure injuries, wandering, medication errors, complaints, challenging behaviour and near misses. Behaviour incidents documented have not been included in the data collection. | On review of incident reports for January 2016, it was noted that three behaviour incident reports have not been included in the monthly collation of data. | Ensure that all data is collated and analysed to identify opportunities for improvement.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Corrective action plans are developed following (but not limited to) internal audits, the annual resident survey, complaints and feedback from resident and staff. Corrective actions are developed for internal audits where compliance has not been fully achieved. Eight of 15 plans developed have been completed and signed off. | Seven of 15 corrective action plans developed following internal audits have not been followed through to completion and sign off. | Ensure that all corrective action plans developed are implemented, and signed off when completed.  90 days |
| Criterion 1.2.4.2  The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Low | Advised by the care home manager that the regional operations manager is notified of any serious events as outlined in Bupa policy for category one incidents and that the responsibility for notifications lies with the upper management team. One incident was not reported in a timely manner. | One incident where Police were notified of a missing resident, was not reported to the Ministry of health under section 31. The incident was reported on the day of audit. | Ensure that all incidents requiring notification are done so in a timely manner.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Incident reports for January 2016 were reviewed. Sixteen reports evidence that caregivers and registered nurses are reporting incidents and that clinical care and first aid is provided in a timely manner. The reports are then forwarded to the clinical manager for further review, investigation and for opportunities for improvement and prevention of reoccurrence to be documented. This has been recorded on 10 of the 16 reports reviewed. | Six of 16 incident reports reviewed did not evidence that further investigations and opportunities for prevention of reoccurrence have been recorded. | Ensure that all incident reports are fully completed and included opportunities to improve care and to identify and manage risk.  60 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | The rostering policy does not fully align with the DHB age related contract. Policies allows for the situation that if a registered nurse is not available to work, another registered nurse is sought to cover a sleep over shift. Advised by the care home manager that an extra caregiver is rostered on, on this occasion. If required, the RN is woken to attend to residents. This has occurred on more than one occasion in the past 12 months. | i) The service, has at times, not been able to provide a registered nurse to cover a full night shift. An RN is on site on a sleep over shift; ii) the policy allows for this to occur which does not align with contractual requirements; and iii) The DHB have not been notified when these occasions occur. | i)Ensure that a registered nurse is on duty on each shift; ii) review staffing policy to align with contractual requirements; and iii) ensure that the DHB is notified if and when a registered nurse is not available to cover a rostered shift.  30 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 | The progress notes and incident reports documented behavioural issues experienced by caregivers and registered nurses (link #1.2.4.3). There was documented evidence of a referral, input and discharge from mental health older persons. Staff interviewed said they were aware of the risk as a result of behaviour that challenges. Advised by the manager, and DHB social worker that they are aware of the risks that this resident poses and that reassessment and case review is scheduled by the needs assessment team. | One resident with well documented behaviours of verbal and physical abuse does not have a behavioural assessment, monitoring or care planning on management of behaviours recorded. | Ensure that there are comprehensive behavioural assessments, continuous documented monitoring and detail interventions in the long term care plan.  30 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 Low | Four of four resident long term care plans reviewed had detailed documented interventions that reflected the needs of the assessments. One respite resident did not have a long term care plan. Evaluations of long term care plans only included a signature and date of evaluation. | Four resident long term care plan evaluations reviewed did not indicate the degree of achievement towards meeting the identified needs /goals. | Ensure that all care plan evaluations identify the resident’s level of achievement against documented needs / goals.  90 days |

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

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

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

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

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End of the report.