

Bupa Care Services NZ Limited - Liston Heights Rest Home & Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Liston Heights Rest Home & Hospital
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: 11 August 2016 End date: 12 August 2016
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	73



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
Yellow	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
Red	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 Liston Heights rest home and hospital is part of the Bupa aged care residential group. The service provides rest home, hospital and dementia level of care for up to 75 residents. On the day of the audit, there were 73 residents.

This certification audit was conducted against 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 resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

The care home manager is a registered nurse and has been in the role for one year. She is supported by a clinical manager with aged care experience and has been in the role for 10 months. The clinical team is supported by a regional operations manager.

The residents and relatives spoke positively about the staff and the care provided at Liston Heights.

There are improvements required around EPOAs, care plan interventions and review of medication charts.

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.		Some standards applicable to this service partially attained and of low risk.
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Staff at Bupa Liston Heights strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Bupa Liston Heights is implementing the organisational quality and risk management system that supports the provision of clinical care. Quality activities are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. An education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster

provides sufficient and appropriate coverage for the effective delivery of care and support. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse completes the assessments and care plans with the resident and/or family/whānau input. Care plans viewed in resident files were individualised and demonstrated service integration. Care plans were evaluated at least six monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. The medicine charts reviewed met legislative prescribing requirements.

A diversional therapist and activity assistant implement the integrated rest home and hospital activity programme for the residents. The programme includes community visitors, outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each consumer group. Caregivers provide activities for residents in the dementia care unit.

All meals and baking is done on-site. Residents' food preferences and dietary requirements are identified at admission and accommodated. The menu is reviewed by the dietitian. There are nutritious snacks available 24 hours. Residents commented positively on the meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident rooms are personalised. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems and training are in place for emergency procedures. There is a first aider on duty at all times.

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.		Some standards applicable to this service partially attained and of low risk.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had two residents using restraint and two 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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

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	45	0	5	0	0	0
Criteria	0	96	0	5	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (five caregivers, five registered nurses, one care home manager, one clinical manager, one regional manager, one cook, one cleaner, one laundry, one maintenance and one diversional therapist), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Low	<p>There are established informed consent policies/procedures and advanced directives. General consents obtained on admission were sighted in the nine resident files reviewed (four hospital including a younger person, three rest home including one rest home in dual-purpose bed and two dementia level of care residents). Advance directives if known were on the resident files. Resuscitation plans for competent residents were appropriately signed. Copies of enduring power of attorney (EPOA) were in resident files for residents deemed incompetent to make decisions. A shortfall was identified around the activation of EPOA for incompetent residents. The provider stated that they discuss EPOA's with families at MDR meetings. They have the conversation with</p>

		<p>families that they need to discuss this with their GP to activate the EPOA.</p> <p>Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. Residents (six rest home and two hospital) and relatives (one hospital and two of dementia level of care residents) interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>All long-term residents' files reviewed had a signed admission agreement.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held quarterly.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using a complaints register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. Nine complaints received since August 2015 were reviewed with evidence of appropriate follow-up actions taken.</p>
<p>Standard 1.1.2: Consumer Rights</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager,</p>

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>the clinical manager and registered nurses discuss aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the resident/family meetings. All eight residents (six rest home level and two hospital level) and four relatives (two hospitals and two dementia) interviewed, report that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff have received training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Two residents identify as Māori are living at the facility.</p> <p>Māori consultation is available through the documented Iwi links and Māori staff who are employed by the service. They have a Māori caregiver who is their cultural advisor onsite. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff received training on cultural awareness in November 2015.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. The residents have retained their own general practitioner. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist's visits. Physiotherapy services are provided on site, sixteen hours per week with the support of a physiotherapy assistant six hours a week. There is a regular in-service education and training programme for staff (link1.2.7.5). A podiatrist is onsite every six-weeks. The service has links with the local community and encourages residents to remain independent.</p> <p>Bupa has established benchmarking groups for rest home, hospital, dementia, psychogeriatric/mental health services. Liston Heights is benchmarked against the rest home hospital and dementia data. Where the results were above the benchmark, a corrective action plan has been developed by the service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Shortfalls were noted around communication with family in three of 17 incident forms sampled between August 2015 – Feb 2016. In May 2016, an internal audit was completed by the service around I&A's with 84% compliance. They identified the issue and implemented a comprehensive CAR well prior to certification. This included training on Incident/Accident form completion on to ensure staff knowledge of the need to notify family of all incidents. Toolbox talks were provided staff. A repeat internal audit identified all relatives have been informed of all incidents. The matter was discussed at MDR meetings and relatives were advised they</p>

		<p>will contact them for all incidents unless advised by written request from family with specific detail of when they do not wish to be informed.</p> <p>Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health 'Long-term Residential Care in a Rest Home or Hospital – what you need to know' is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Liston Heights Rest Home and Hospital is a Bupa residential care facility. The service currently provides care for up to 75 residents at hospital (medical, geriatric), rest home and dementia level care. On the day of the audit, there were 73 residents. There were 26 hospital residents and 6 rest home residents in the hospital wing [all 32 rooms in the hospital wing are dual-purpose] and 29 rest home residents and one hospital resident in the 31 bed rest home wings. There were 11 residents in the 12-bed secure dementia wing. The rest home services are delivered across two floors. Two hospital residents are funded by a Māori health care provider, including one resident admitted under a young person with disability contact. All other residents were under the aged related contract. There were no respite residents.</p> <p>A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan.</p> <p>Liston Heights is part of the midlands Bupa region and the managers from this region meet quarterly to review and discuss the organisational goals and their progress towards these. The care home manager provides a weekly report to the Bupa operations manager. The operations manager teleconferences monthly and completes a report to the director of care homes and rehabilitation.</p> <p>A quarterly report is prepared by the care home manager and sent to the Bupa quality and risk team on the progress and actions that have been taken to achieve the Liston Heights quality goals.</p> <p>Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is</p>

		<p>also carried out with facilities in the UK, Spain and Australia, (eg, mortality and pressure incidence rates and staff accident and injury rates). Benchmarking of some key indicators with another NZ provider is also in place.</p> <p>The care home manager has been in the role since June 2015. The care home manager is registered nurse with a current practising certificate. She has held managerial district health board (DHB) roles including associate director of nursing. She holds a master's degree in nursing and has a postgraduate diploma in health science. A clinical manager has been in the role since March 2016. The clinical manager was previously a registered nurse at Liston Heights. Staff spoke positively about the support/direction and management of the current management team.</p> <p>The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>A clinical manager/registered nurse (RN) who is employed full time, supports the care home manager, and steps in when the care home manager is absent. The operations manager, who visits regularly, supports both managers.</p> <p>The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and promotes quality of life.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management programme is well established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems.</p> <p>The Quality Goals for 2016 include (i) Increase RN participation in PDRP, (ii) reduce resident falls across the facility by 10% from 2015 and (iii) reduce the number of pressure areas by 20% from 2015. Actions, and progress to meeting these goals is documented.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of</p>

		<p>internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed.</p> <p>Resident satisfaction survey results for 2016 improved from 88% in 2015 to 96% in 2016. A corrective action plan is being implemented to ensure a higher return rate for 2017.</p> <p>Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements.</p> <p>Falls prevention strategies are in place. A health and safety system is in place. Hazard identification forms and a hazard register are in place. The maintenance person is the health and safety officer and has completed health and safety and investigation training.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Individual reports are completed for each incident/accident, with the immediate action noted and any follow-up action(s) required. Each event involving a resident reflected an initial clinical assessment by a registered nurse. Not all follow-up actions had been fully completed (link 1.3.6.1). Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Seventeen accident/incident forms were reviewed. Incidents are benchmarked and analysed for trends.</p> <p>Discussions with the care home manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Appropriate notification was made around the outbreak in June 2016.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Nine staff files reviewed evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. New staff are buddied for a period of time (eg, caregivers two weeks, RN four weeks), and during this period they do not carry a clinical load. The caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this, they are then able to continue with Core</p>

		<p>Competencies Level 3 unit standards. These align with Bupa policy and procedures.</p> <p>A new orientation schedule has been introduced in 2016 for new staff. This is an orientation day off the floor, for newly recruited staff in the last 3 months, to ensure they are supported with the completion of their orientation documentation. The content of the day aligns with their orientation book.</p> <p>There is an annual education and training schedule being implemented. Attendance numbers at education sessions has not been consistently high. Opportunistic education is provided via toolbox talks. Education and training for clinical staff is linked to external education provided by the district health board.</p> <p>A competency programme is in place with different requirements according to work type (eg, support work, registered nurse, and cleaner). Core competencies are completed annually and a record of completion is maintained (signed competency questionnaires sighted in reviewed files).</p> <p>RN competencies include assessment tools, blood sugar levels/insulin administration, controlled medications, moving & handling, nebuliser, oxygen administration, tube feeds, restraint, wound management, cardiopulmonary resuscitation and syringe driver.</p> <p>Eight of fourteen registered nurses are InterRAI trained. Eight of 10 caregivers working in the dementia unit have completed the required dementia course modules qualifications. Two staff have been employed less than 6 months and have commenced the required training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing levels meet contractual requirements. The care home manager and the clinical manager are on-call after hours. The care home manager and clinical manager are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of caregivers' support RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.</p> <p>Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the</p>

		relevant caregiver or nurse, including designation.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs are provided for families and residents prior to admission or on entry to the service. Seven admission agreements reviewed (for long-term residents) align with all contractual requirements. Exclusions from the service are included in the admission agreement.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs, ENs and caregivers) have been assessed for competency on an annual basis. Registered nurses have completed syringe driver training. Education around safe medication administration has been provided annually. There is evidence of medication reconciliation on delivery of medications. Medication fridges are checked daily and are maintained within the acceptable temperature range. All eye drops were dated on opening. Each resident has a current standing order. There were no self-medicating residents.</p> <p>Medication chart prescribing meets legislative requirements. Eighteen medication charts reviewed (eight hospital, six rest home and four dementia care) had photo identification and allergy status documented on the chart. The administration sheets corresponded with the medication charts. Thirteen medications charts evidenced three monthly GP review. The GP or psychogeriatric team monitor the use of antipsychotic medication.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of</p>	FA	All meals and baking are prepared and cooked on site by two cooks. Cook assistants and kitchenhands support them. Food services staff have attended food safety training. The four weekly seasonal menu has been reviewed by a dietitian. Meals are served directly to the hospital dining area from the kitchen bain-marie. Food is delivered to the kitchenette bain-maries in the rest home and dementia care unit. The cook receives a resident dietary profile for new residents and is notified of any dietary changes. Likes and dislikes are known. Special diets are accommodated including

<p>service delivery.</p>		<p>diabetic desserts and non-protein diet (until 5pm) and modified foods. The cook is notified of any residents with weight loss. Protein drinks and fluids were available in the kitchenette fridges. There were nutritious snacks available 24 hours in the dementia unit.</p> <p>Fridge, freezer and end cooked meat temperatures are taken and recorded daily. Perishable foods sighted in the kitchen and facility kitchenette fridges were dated. The dishwasher is checked regularly by the chemical supplier. Staff have received training in chemical safety. Chemicals are stored safely. A cleaning schedule is maintained.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RN completes an initial assessment booklet on admission including relevant risk assessment tools. An InterRAI assessment is undertaken within 21 days of admission and six monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summary were in place for the long-term resident files reviewed. The long-term care plans reflected the outcome of the assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>The resident care plans reviewed were resident-focused and individualised. Overall resident files reviewed identified support needs as assessed were included in the care plans. However some interventions could be more descriptive. Short-term care plans were in use for changes to health status and have been resolved or if ongoing transferred to the long-term care plan. Care plans included the management of behaviours, triggers, interventions and de-escalation techniques including activities over a 24-hour period. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were</p>

		<p>involved in the care planning process. Resident files demonstrate service integration.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including GP, psychogeriatrician, community mental health nurse and physiotherapist.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP, nurse specialist consultation. There was documented evidence that family members were notified of any changes to their relative's health status. Discussions with families were recorded on the family/whānau contact sheet in the resident files reviewed.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for eight hospital residents and four rest home residents. There were no residents in the dementia care unit with wounds. One chronic wound documentation evidenced wound nurse specialist involvement in the management of the wound.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Monitoring charts were in place for observations, specific recordings, weight, food and fluid, neurological observations, behaviour, wounds and restraints.</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs a qualified diversional therapist (DT) and an activity assistant who work a four day on, four days off roster. The integrated rest home and hospital activity programme covers seven days a week. Activities are held within the hospital or rest home and open to all residents. The activity team provide individual and group activities for rest home and hospital residents that includes; craft, music, exercises, reminiscing, entertainers and outings. One-on-one activities occur such as individual walks, reading and chats and nail/hand care for residents who are unable or choose not to be involved in group activities. Community links are maintained with church groups, grey power, age concern, community speakers and other community clubs and groups.</p> <p>Caregivers on duty in the dementia unit incorporate resident small group and individual activities as part of their duty. Individual participation records are maintained. Caregivers interviewed were able to describe how they met the resident's individual recreational preferences. Activities were observed in the unit on the day of audit.</p> <p>An activity assessment is completed on admission. Socialising and activities is included in the My</p>

		Day, My Way care plan. The DT is involved in the six monthly review. The service receives feedback and suggestions for the programme through surveys and resident meetings. Monthly newsletters inform residents and relatives on upcoming activities and events.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The care plans had been reviewed by the multidisciplinary team (MDT) at least six monthly or earlier for any health changes. Family are invited to attend the MDT review and are informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and are evident in changes made to care plans.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety datasheets are readily accessible for staff. Chemicals were correctly labelled and stored safely throughout the facility. A chemical spills kit is available. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training provided by the chemical supplier.
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 has a current building warrant of fitness that expires 1 July 2017. The building has two levels with lift and stair access between the two rest home wings. The service employs a full time maintenance person who is a health and safety officer. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24 hours. Electrical testing is completed annually. An external contractor completes annual calibration and functional checks of medical equipment. The maintenance person carries out regular checks of transferring equipment and

		<p>company vehicles.</p> <p>Hot water temperatures in resident areas are monitored and maintained at 45 degrees Celsius.</p> <p>The facility has wide corridors with rails and sufficient space for residents to safely mobilise using mobility aids or for the use of hoists and hospital recliners on wheels.</p> <p>There is safe access including ramp access to the outdoor areas. Seating and shade is provided. The dementia unit has a safe indoor and outdoor environment with a deck, seating, shade and raised gardens. Environmental improvements include upgrading of bedroom floors to vinyl and the replacement of mattresses with high pressure injury prevention rating properties.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Rest home rooms all have ensuites. There is a mix of hospital rooms with and without ensuites. There are adequate numbers of toilets and shower facilities in the hospital wings. The dementia unit has adequate communal toilets and showering facilities identified with the same colour doors and large pictorials. All rooms have hand basins. Residents interviewed confirm care staff respect the resident's privacy when attending to their personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single and spacious. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	FA	<p>Communal areas within the facility include a large main lounge and a smaller lounge in the hospital wings. The large hospital dining room is adjacent to the kitchen. There are seating alcoves throughout the facility. Both rest home wings have lounge and dining areas. The lounge and dining area in the dementia unit is open plan.</p> <p>Seating and space in the lounges is arranged to allow both individual and group activities to occur.</p>

<p>accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>All communal areas are accessible to residents. Care staff assist or transfer residents to communal areas for dining and activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff on duty seven days a week. The laundry and cleaning staff have completed chemical safety training. There is an entry and exit door with defined areas for clean and dirty laundry. The cleaner's trolleys are stored in locked areas when not in use. Internal audits monitor the effectiveness of the cleaning and laundry processes. The chemical supplier conducts quality checks on the effectiveness of washing and cleaning processes. The laundry has a labeller for residents clothing to minimise lost items.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service on 19 June 2016 following changes to the existing fire system. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation attendance documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment including oxygen and suction is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, backup gas boilers, gas cooking and barbeque. There is an arrangement with a local contractor to provide a generator on request. Emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, toilets and showers and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The facility is secure after hours with call bell access at the front entrance.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is radiator heating throughout the facility including the resident rooms. The residents and family interviewed confirmed the temperature of the facility is comfortable.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control coordinator is the clinical manager and is responsible for infection control across the facility. The committee and the Bupa governing body in conjunction with an external consultant is responsible for the development of the infection control programme and its review. The infection control programme is well established at Liston Heights. The infection control committee consists of a cross-section of staff and there is external input as required from general practitioners, Bupa quality & risk team.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Liston Heights. The infection control (IC) nurse has maintained best practice by attending infection control updates and has completed a postgraduate diploma in infection control. The infection control team is representative of the facility. External resources and support are available through the Bupa quality & risk team when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around hand hygiene and standard precautions. Infection control training is regularly held, including (but not limited to) food safety August 2016, standard precautions and infection prevention & control (July 2016).</p>

consumers.		<p>The infection control coordinator has received education both in-house and by an external provider to enhance their skills and knowledge. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice and group benchmarking.</p> <p>A number of toolbox talks have been provided including (but not limited to) preventing UTIs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff.</p> <p>Infections statistics are included for benchmarking. Corrective actions are established where trends are identified. An outbreak of sapovirus in June 2016 was appropriately managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and regional restraint meetings and at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had two hospital residents using restraint (bedrails) and two hospital residents with enablers (bedrails). All enabler use is voluntary. Two files of residents using a restraint and two files of residents using an enabler were reviewed. The enabler and restraint assessment forms were completed and correctly signed. These had been evaluated at least three monthly.</p>
Standard 2.2.1: Restraint approval and processes	FA	<p>Only staff that have completed a competency assessment are permitted to apply restraints. Competency assessments expire annually and are renewed by the restraint coordinator. There is a</p>

<p>Services 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.</p>		<p>responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisation level and a service level. The restraint coordinator is a registered nurse and has a signed job description, and understands the role and her accountabilities.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. A registered nurse is the restraint coordinator.</p> <p>Restraint assessments are based on information in the care plan, resident discussions and on observations of the resident by the staff. There were restraint assessment tools completed for two hospital residents requiring bedrails for safety. The care plan was up-to-date and provides the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified. Falls risk assessments are completed six monthly and InterRAI assessment identifies risk and need for restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>PA Low</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used.</p> <p>The resident's file reviewed refers to specific interventions or strategies to try (as appropriate) before use of restraint. The care plans were reviewed of the residents using restraint and enablers and the care plans identified the observations and monitoring required. Not all residents using an enabler had a care plan and not all required monitoring was documented. Restraint use is reviewed through the three monthly assessment evaluation, monthly restraint meetings and six monthly multidisciplinary meeting and includes family/whānau input. A restraint register is in place, which has been completed for all residents using a restraint or enabler.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the regional restraint approval group and information is disseminated throughout the organisation. The organisation and facility are very proactive in minimising restraint usage.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	PA Low	<p>Copies of EPOA are available in the residents file. Five of nine residents were deemed to be incompetent. The EPOA of one resident had been activated by a GP letter of mental capacity.</p>	<p>The four residents deemed incompetent to make decisions relating to health and welfare did not have documented evidence that the EPOA had been activated. Advised that they discuss this with families at MDR meetings. They have the conversation with families that they need to discuss this with their GP to activate the EPOA.</p>	<p>Ensure EPOAs are activated as required.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A 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.</p>	PA Low	<p>Medication charts are pharmacy generated and meet legislative requirements including 'indications for use' of 'as required' medication. The prescriber has reviewed 13 medication charts at least three monthly.</p>	<p>Five of 18 medications charted did not evidence that three monthly reviews had been completed by the GP.</p>	<p>Ensure medication charts are documented as reviewed three monthly.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Three of nine resident files reviewed identified all required needs and interventions to meet resident goals. Short-term care plans had been completed for wounds, infections and short-term needs.</p>	<p>There were limited interventions documented for; a) two hospital residents with high risk of pressure injury, b) one hospital resident identified as a choking risk, c) two rest home residents at risk of absconding and d) one hospital resident with a change in medical condition as documented in the medical notes. As there were interventions documented, but could be more detailed this has been identified as low risk.</p>	<p>Ensure care plans reflect the resident's current needs and supports.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Monitoring occurs for weight, vital signs, blood sugar levels, pain, challenging behaviour, repositioning charts, food and fluid, restraint and visual checks.</p>	<p>Visual checks had not been documented as completed for two rest home residents at risk of absconding.</p>	<p>Ensure monitoring requirements are completed as required.</p>

		Visual checks had not been documented as completed for two rest home residents at risk of absconding.		90 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	PA Low	<p>Restraint and enabler care plans are documented by the registered nurse and or the restraint coordinator. Not all residents using an enabler had an enabler care plan. Staff report that they regularly check on residents while restraint and enablers are in use, but this is not being consistently documented on the restraint monitoring forms.</p>	<p>i) One of two residents (hospital) using an enabler did not have an enabler care plan documented.</p> <p>ii) Monitoring was not consistently documented for two hospital residents using a restraint and two hospital residents using an enabler.</p>	<p>i) Ensure that all residents using a restraint or enabler have a documented care plan.</p> <p>ii) Ensure that the monitoring and observations of residents using a restraint or enabler is consistently documented.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.