# Bupa Care Services NZ Limited - Kauri Coast Hospital & 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:** Kauri Coast Hospital & Rest Home

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 29 November 2017 End date: 30 November 2017

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 47

# 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** |
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|  | 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 Kauri Coast is part of the Bupa aged care residential group. The service provides rest home and hospital level of care for up to 52 residents. On the day of the audit there were 47 residents.

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, management and staff.

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

The residents and relatives spoke positively about the staff and the care and services provided at Kauri Coast

Three of four previous findings have been addressed in relation to meeting minutes, interRAI assessments and restraint evaluations.

Further improvements continue to be required around interventions.

There were two areas for improvement identified at this audit around complaints and enabler consents.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Residents and family are well informed, including of changes in residents’ health. The facility manager and clinical manager have an open-door policy. Complaint forms and advocacy brochures are available. There is a current complaint register. Learnings from complaints are shared with all staff.

## Organisational management

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

Bupa Kauri Coast has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. The facility is benchmarked against other Bupa facilities. Incidents documented demonstrated immediate follow-up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

## 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 registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records were individualised and demonstrated service integration. Care plans are evaluated at least six monthly. InterRAI assessment timeframes had been met. Resident files included medical notes by the general practitioner and visiting allied health professionals.

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

An activity coordinator coordinates and implements the 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 resident group including younger people.

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

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

There is a Bupa restraint policy that includes comprehensive restraint procedures including restraint minimisation. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There was one restraint and five enablers being used.

## 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 surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

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

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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 | 14 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 2 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the care home manager using a complaint register. Documentation including follow-up letters and resolution demonstrates that complaints are being managed. Not all complaint responses were completed within the contractual timeframes in accordance with guidelines set forth by the Health and Disability Commissioner.  Discussions with the residents confirmed they were provided with information on complaints and complaints forms. Complaints forms, and a suggestions box are in a visible location at the entrance to the facility. Nine complaints received in 2017 and nine from 2016 were reviewed with evidence of appropriate follow-up actions taken. There has been one health and disability complaint which is ongoing. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accidents and incidents are entered onto the on-line reporting tool, Riskman. Riskman have a section to indicate if family/whānau have been informed (or not) of an accident/incident. Twelve accident/incident forms reviewed identified family are kept informed. Six residents (three rest home and three hospital) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. No relatives visited on the day of audit. An interpreter policy and contact details of interpreters is available and used where indicated. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Kauri Coast is a Bupa residential care facility. The service currently provides care for up to 52 residents at hospital and rest home levels of care. On the day of the audit there were a total of 47 residents. There were 15 rest home and 32 hospital level care residents. There were three hospital level residents under YPD contracts, two residents under respite contracts (one resident in the rest home and one in the hospital in a contracted DHB bed) and one on an ACC contract (hospital). All other residents were under the aged related residential care (ARRC) contract. 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.  The manager at Kauri Coast is a registered nurse (RN) who has been in the care home manager (CHM) position since April 2017. She previously worked as the clinical manager and registered nurse (RN) at the facility for a number of years. The care home manager is supported by a clinical manager (RN) who has been in the role since June 2017. The management team is supported by a facility unit coordinator (RN). There are job descriptions for the management team that include responsibilities and accountabilities. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly. The care home manager and clinical manager have maintained at least eight hours annually of professional development activities related to managing a hospital. |
| 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. | FA | An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings. Discussions with the managers and staff reflected staff involvement in quality and risk management processes. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed and new policies or changes to policy are communicated to staff.  The monthly monitoring, collation and evaluation of quality and risk data is comprehensive. Quality and risk data, including trends in data and benchmarked results are discussed in the quality and applicable staff meetings. The previous finding around meeting minutes has been addressed. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are established, implemented and are signed off when completed. Caregivers and RNs interviewed were aware of the corrective actions and described receiving toolbox education sessions on pressure injury prevention, falls prevention, moving and handling, and skin care.  Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the Health and Safety Committee. Health and safety representatives (CHM and caregiver) were interviewed about the health and safety programme. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. The resident satisfaction survey for 2017 showed an overall improvement of 20% above the 2016 results.  Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes sensor mats and chair alarms. Workplace safety strategies include moving and handling champions and provision of additional sliding sheet resources for residents who require them. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Twelve accident/incident forms were reviewed for October 2017. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observations are conducted for unwitnessed falls. Data collected on incident and accident forms are linked to the quality management system. The care home manager and clinical manager are aware of their requirement to notify relevant authorities in relation to essential notifications. |
| 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 | Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (one clinical manager, one RN, one caregiver, one cook and one activities officer) all documented a recruitment process, signed employment contracts, job descriptions, appraisals and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. 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 (e.g., RN, support staff) and includes documented competencies.  There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. Registered nurses are supported to maintain their professional competency. Eight RNs are employed and six have completed their interRAI training. There are implemented competencies for RNs including (but not limited to) medication competencies, assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management, CPR and syringe driver. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There is a full-time care home manager and clinical manager/RN who work from Monday to Friday. Registered nurse cover is provided 24 hours a day, 7 days a week. Registered nurses are supported by sufficient numbers of caregivers. Separate laundry and cleaning staff are employed seven days a week. Interviews with the residents confirmed staffing overall was satisfactory. Interviews with two caregivers (morning shift) confirmed that staffing numbers were satisfactory.  St Joseph Hospital wings (22 beds)– includes a dedicated respite room. Current occupancy 20 hospital residents  AM shift – unit coordinator (RN) 0800-1600  1 X RN 0700- 1515  2 x caregivers 0700 – 1500, 1 caregiver 0700 – 1330  PM shift  1 X RN am shift X 7 days, 0700- 1515  2 x caregivers 0700 – 1500, 1 caregiver 0700 – 1330  1 x RN 1500 -2315  -3 caregivers (2 long, one short shift)  Night shift  1 x RN and 1 caregiver  Laura Ambury 30 beds (dual purpose)- current occupancy 12 hospital and 15 rest home  AM shift  Team leader (RN or senior caregiver) 0700 - 1515  3 x caregivers (2 long, one short shift)  PM Shift  Team leader (RN or senior caregiver) 1500- 2315  2x caregivers 1500 -2200 and 1530 – 2030  Night shift  Enrolled nurse (or senior caregiver) and one caregiver |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for safe medicine management that meet legislative requirements. Staff who administer medications (RNs and senior 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 (robotic rolls). The medication fridge is checked daily and temperatures recorded are maintained within the acceptable temperature range. All eye drops were dated on opening. Standing orders are not used. There were no self-medicating residents on the day of audit.  Ten medication charts on the electronic medication system were reviewed. All medication charts met prescribing legislative requirements for regular and ‘as required’ medications. All medication charts had photo identification and allergy status documented on the chart. The administration sheets corresponded with the medication charts. The medications charts evidenced three monthly GP review. |
| 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 | All meals and baking are prepared and cooked on-site a qualified head cook and second cook who cover the seven-day week. They are supported by kitchenhands. All staff have completed food safety training. The organisational four-weekly seasonal menu has been reviewed by the company dietitian. The menu has a vegetarian option and diabetic desserts. Modified meals are provided. The daily menu is displayed. An alternative menu and options are displayed for residents with dislikes. The cook receives a resident nutritional requirement form and is notified of any dietary changes.  Fridge, freezer and end cooked meat temperatures are taken and recorded daily. Perishable foods sighted in the fridges were date labelled. 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.  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. |
| 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 | 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. Changes to resident health and required supports is updated on the care plans. A review of five files identified that not all interventions had been documented for all assessed needs.  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 six hospital and two rest home residents with wounds. There was one hospital respite care resident with a stage three community acquired pressure injury on the day of audit. Photos demonstrate progress towards healing. The district nursing service is available as required for advice on wound management.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. |
| 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 | The service employs an activity coordinator to provide an integrated rest home and hospital activity programme Monday to Friday from 8.00 am to 3.30 pm. A volunteer assists with the activities three days a week including bingo, bowls, board and word games and knitting club. There are regular musical entertainers and visitors to the facility including school choirs, school children and babies and visitors with their dogs. There are twice weekly outings to places of interest, shops and cafés, picnics, community functions and inter-home bowls competitions. 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. Individual activities are identified for residents under 65 years of age and residents are supported and encouraged to attend community activities of their choice.  Residents are encouraged to maintain community links such as library visits, shopping outings into the community. Church services are held regularly.  An activity assessment and Map of Life is completed on admission. Socialising and activities is included in the My Day, My Way care plan. The activity coordinator is involved in the six-monthly MDT review. The service receives feedback and suggestions for the programme through surveys and resident meetings. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed were evaluated by the RN within three weeks of admission. The long-term care plans had been reviewed by the multidisciplinary team (MDT) at least six monthly or earlier for any health changes against the resident goals as being met or unmet. Family are invited to attend the MDT review and 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 1.4.2: 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 3 March 2018. |
| 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 infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. 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. Effective monitoring is the responsibility of the infection control coordinator. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where trends are identified. There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | PA Low | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. There is one hospital resident requiring the use of restraint (bed rail). There are five hospital residents requiring the use of an enabler (bedrails). Use of an enabler is voluntary. An assessment for restraint/enabler use and consent forms are completed in the restraint file. Not all enabler files identified the resident was able to give voluntary consent. The care plans reviewed document the use of enabler or restraint but not all care plans contain appropriate interventions (link 1.3.6.1). Kauri Coast has a restraint coordinator who oversees all restraint. Restraint education and audits have been completed. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Click here to enter text |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | All complaints are documented on a monthly complaint register. All complaints evidenced investigation including interviews and review of documentation. Where indicated corrective actions were documented and included (but not limited to) staff training, food surveys, care reviews, communication memos and newsletters. | (i)Four of 18 complaints initial responses were either not dated or responses were outside timeframes as set out in code 10 of the HDC Code of Rights. (ii) Six of 18 investigation outcomes were either not documented or outside expected timeframes | Ensure all initial responses and follow-up outcomes are responded to and meet code 10 of the HDC code of rights.  90 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 | Short-term care plans document appropriate interventions to manage short-term changes in health. Care staff interviewed were knowledgeable about the resident supports and needs. Documentation sighted described interventions for the management of pain, pressure injury prevention, and behaviour management and this is an improvement on the previous audit. However, not all interventions had been documented in regard to enabler use and GP request for monitoring. Monitoring occurs for weight, vital signs, blood sugar levels, pain, challenging behaviour, repositioning charts and food and fluid charts. Monitoring forms in place had been completed and reviewed by the RN. | 1) The associated risks of enabler use had not been documented for four of five residents using enablers.  2) There were no documented interventions for one hospital resident requiring monitoring of oedematous legs as per GP notes. | 1) Ensure risks of enabler use are documented in the care plans.  2) Ensure GP requests for monitoring are documented and followed up.  90 days |
| Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | All residents using restraint and enablers have pre-assessments completed and consent forms are on file. Reviews are completed three monthly. Residents are monitored while restraints and enablers are in use. | Three of four residents using enablers did not evidence voluntary consent. | Ensure all resident using enablers are appropriately assessed and able to voluntarily consent to the use of an enabler.  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.