

# Tairua Residential Care Limited - Tairua Residential Care

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## 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:

<b>Legal entity:</b>	Tairua Residential Care Limited
<b>Premises audited:</b>	Tairua Residential Care
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 19 February 2018      End date: 20 February 2018
<b>Proposed changes to current services (if any):</b>	Nil
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	40

# Executive summary of the audit

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## 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

Tairua Residential Care can provide care for up to 44 residents requiring either rest home; hospital (medical or geriatric) level of care. On the day of the audit, there were 40 residents in total.

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 residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner.

The general manager is responsible for operational management of the facility and is supported by the clinical nurse manager who provides clinical oversight. Service delivery is monitored.

Improvements are required to the following: documentation to confirm that family have been informed of incidents; recruitment process; timeliness of completion of interRAI, assessments; and care plan interventions.

## Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Residents receive services in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The systems protect their privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Management and staff communicate in an open manner and residents and relatives are kept up-to-date when changes occur. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices.

The rights of residents or their legal representatives to make a consumer complaint is understood, respected and upheld. An up-to-date complaints register is maintained.

## Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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There is an annual business, quality and risk management plan in place which defines the scope, direction and objectives of the service and the monitoring and reporting processes. The service is managed by the general manager who is a registered nurse with a current practising certificate.

The framework around a quality and risk management system is documented. There are a range of policies and forms in place to guide practice. Quality outcomes data is collected with a process in place to record adverse events.

The human resource management system is documented. There is an orientation programme in place.

There is a documented rationale for determining staff levels and staff mix in order to provide safe service delivery in the rest home and hospital. An appropriate number of skilled and experienced staff are allocated each shift with a full complement of registered nurses now in place.

Resident information is stored securely.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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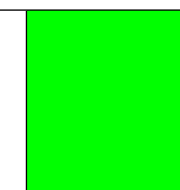
There is an admission information package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are evaluated at least six monthly. Resident files include medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses, and senior healthcare assistants are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed met legislative prescribing requirements.

The activity coordinators provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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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 bedrooms 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. Documented systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. Processes to assess for the need for restraint, consent by family and the general practitioner, care planning and monitoring of any use of restraint are in place with evaluation overall of use of restraint completed as per policy. There are two residents at the service using enablers and three residents with restraint.

## 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. Responsibility for infection control is the clinical nurse manager. The infection control coordinator has completed on-line training. Staff complete annual training on infection control. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility.

## 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)
<b>Standards</b>	0	45	0	4	1	0	0
<b>Criteria</b>	0	96	0	4	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	<p>FA</p>	<p>Policies and procedures are in place to ensure consumer rights are respected by staff. Staff receive education during orientation and ongoing training on consumer rights is included in the staff annual training schedule.</p> <p>Managers (including the general manager and clinical nurse manager) and staff interviewed (including four caregivers; two registered nurses; the diversional therapist and activities coordinator; household staff including the cook, maintenance, laundry and cleaner) are all able to articulate knowledge of the Health and Disability Commissioner’s Health and Disability Services Consumers’ Rights (the Code) and how to apply this as part of their everyday practice. Staff interviewed confirm they receive ongoing education on the Code and they are able to articulate how they apply this knowledge to everyday practice.</p> <p>Visual observations during the audit and the review of clinical records and other documentation indicate that staff are respectful of residents and incorporate the principals of the Code into their practice. The service provides information on the Code to families and residents on admission.</p> <p>Residents and family interviewed state that they receive services as per 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>	<p>FA</p>	<p>There is an informed consent policy in place. Documentation of consent is included in each resident's record. Staff use verbal consents as part of daily service provision. Staff demonstrate an understanding of informed consent processes.</p> <p>Residents and relatives confirmed that consent issues are discussed with the relatives and residents on admission. All residents' files reviewed include documented written consent.</p> <p>There is a policy that reflects evidence and best practice around advanced directives. Residents deemed competent by the general practitioners complete an advance directive if they chose.</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>	<p>FA</p>	<p>There are policies in place regarding advocacy and/or support services.</p> <p>Advocates can be accessed through the Nationwide Health and Disability Advocacy Service if required. The Nationwide Health and Disability Advocacy Service brochure is offered to the resident and their family/whānau on admission. These brochures are also displayed in the entrance foyer. Education on advocacy is provided to staff during orientation and in the ongoing in-service programme.</p> <p>Residents and relatives interviewed confirm they are aware that advocacy services are available should they be needed.</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>	<p>FA</p>	<p>Residents have open access to visitors of their choice. Resident safety and well-being is not compromised by visitors to the service. Access to community support/interest groups is facilitated for residents as appropriate. The activities staff are available to take residents on community visits and staff are available to take people to appointments if family are not able to provide transport. There is a volunteer who can drive residents into the community as required.</p> <p>Residents interviewed confirm they can have access to visitors of their choice at any time and are supported to access services within the community. Family were seen visiting residents on the days of audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected,</p>	<p>FA</p>	<p>The complaints management policy and procedure is documented and follows Right 10 of the Code. The complaints policy and procedure is explained by the staff as part of the admission process.</p> <p>There are complaint forms available at the main entrance to the building. The general manager</p>

<p>and upheld.</p>		<p>manages resident complaints. An up-to-date resident complaints register is maintained as part of the Towards Improving Services (TIS) forms, with these including a monthly register of any complaints.</p> <p>Three complaints were tracked with these resolved in a timely manner as per policy. Staff, residents and families interviewed have a good understanding of the complaints process.</p> <p>Family and residents interviewed state that they have not had to complain formally but state that any suggestions are treated seriously, with improvements when appropriate.</p> <p>There have been no complaints from external authorities since the last audit as confirmed by the general manager.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Information on the Code and the Nationwide Health and Disability Advocacy Service is displayed in the facility and included in the admission information pack. The Code and other rights and information in the information pack are discussed with residents and relatives on admission.</p> <p>Residents and relatives interviewed confirm that the Code, the advocacy service and residents' rights are explained on admission.</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>	<p>FA</p>	<p>There are a range of policies and procedures in place to ensure residents are treated with respect. Staff endeavour to maximise residents' independence. There is respect for residents' spiritual, cultural and other personal needs.</p> <p>The service has a philosophy that promotes dignity and respect and quality of life. Residents' support needs are assessed using a holistic approach. The assessment process includes gaining details regarding people's beliefs and values. Residents and family confirm that they are included in the care planning process and are addressed by their preferred name.</p> <p>Caregivers state that they support the residents' independence by encouraging them to be as active as possible. Caregivers can describe how they encourage each resident to remain involved in and with the community. Residents interviewed could describe how they were supported to visit friends and were observed to be in the township.</p> <p>A policy is available for staff to assist residents in managing personal practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner. This includes strategies to manage any behaviours of concern. Staff are able to describe support for residents around sexuality and intimacy.</p>

		<p>The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility that can be used for private meetings. Caregivers report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit and confirmed by residents interviewed.</p> <p>Residents and relatives interviewed state that staff have regard for the dignity, privacy, and independence of residents.</p> <p>There is a policy around abuse and neglect. Staff can describe the process for managing any issues related to abuse and neglect. Staff, residents and family and the general practitioner interviewed state that there is no evidence of abuse or neglect.</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>There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff in care provision for Māori residents. The documentation is referenced to the Treaty of Waitangi and includes guidelines on partnership, protection, and participation.</p> <p>Staff interviewed confirm an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training at least annually.</p> <p>There is one staff member in the service who identifies as Māori and they can support other staff with advice if required and residents who wish to speak Te Reo. On the days of audit there were no residents who identify as Māori.</p> <p>Access to Māori support and advocacy services are available if required. Systems are in place to allow for review processes including input from family/whānau as appropriate, for residents who identify as Māori.</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>There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan.</p> <p>Staff interviewed confirm their understanding of cultural safety in relation to care.</p> <p>Residents and family members interviewed confirm that values and beliefs are respected by staff.</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>There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions.</p> <p>Staff interviewed demonstrate an awareness of the importance of maintaining boundaries with residents. Residents and relatives interviewed report that staff maintain appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Residents state that they receive a high quality of service and all state that they enjoy living at the facility. Family also confirm residents' acknowledgement of the quality of service. Residents and family describe a culture of caring and support that extends over and above the expected norm.</p> <p>There are policies and procedures in place to guide service delivery. Management and staff have access to, and demonstrate knowledge of, approved service standards. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice.</p> <p>The education programme includes training requirements for staff with external experts facilitating some training sessions. Staff interviewed confirm that there is a supportive environment.</p> <p>The general manager maintains strong links with the community and she has an extensive knowledge of family/whānau links. This includes knowledge and understanding of resident's needs relative to their community.</p> <p>The general practitioner interviewed praised the service for the quality of care provided.</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>PA Low</p>	<p>The service provider has policies covering communication, access to interpreters and the general manager maintains an open-door policy. Information is provided in a manner that the resident can understand. Relatives and residents state that they can discuss issues at any time with staff. Resident meetings are conducted monthly and residents interviewed confirm that these are useful forums to raise any issues.</p> <p>The incident and accident forms include an area to document if the relatives have been contacted following an incident or accident. Not all are completed as per policy.</p> <p>Residents and relatives interviewed confirm that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirm that they are advised if there is a change in their family member's health status. The general practitioner interviewed, reported</p>

		<p>satisfaction with communication by staff.</p> <p>Interpreting services are available through the district health board. There are no residents requiring the use of interpreting services.</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>	FA	<p>Tairua Residential Care has been in operation since April 2011 and is privately owned. The service provides for residents requiring rest home or hospital level of care with 29 residents requiring rest home level of care (32 beds identified as being available for residents requiring rest home level of care including one resident on respite), and 11 requiring hospital level care (12 available beds) including one on ACC.</p> <p>The philosophy, mission statement and values are documented and known to staff, residents and family members. The mission statement is 'to assist residents, respectfully and with dignity; to safely enjoy life, love and laughter in their own way, time and space'.</p> <p>Organisational performance is monitored by the general manager with the clinical nurse manager taking clinical oversight along with the general manager. The general manager has over 40 years nursing experience and 20 years' experience in rest home and hospital management. They have maintained training relevant to clinical and management areas.</p> <p>The clinical nurse manager is a registered nurse with a current practising certificate and has been in the role for over a year. Prior to this she was employed by the district health board as a solicitor and prior to that as infection control nurse specialist. She has 18 months experience in aged care and over 15 years' experience in nursing and in management roles.</p> <p>Both the clinical nurse manager and the general manager have completed at least eight hours of education in the last year to maintain their practising certificates.</p> <p>A business plan for 2018 is documented and this includes business goals and objectives, accountabilities, timeframes and measures to report against. There is an annual review of the business goals with recommendations for the next business plan. Recommendations are linked to recent changes in legislation. An organisational risk management plan is documented with this reviewed annually and as changes occur. A marketing plan is documented and reviewed annually.</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</p>	FA	<p>The general manager is a registered nurse and provides a leadership role. She is knowledgeable and experienced, with staff stating that the general manager provides leadership for the organisation. The clinical nurse manager has prior experience in management roles at the district health board and is able to provide cover for the general manager in the event of her absence. The</p>

<p>manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>general manager also states that she is always in phone contact even if absent.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></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>The quality and risk management programme identifies objectives for the service. A quality plan is documented with goals, accountabilities, timeframes and measures to report against. There is an annual review of the quality plan with this completed in December 2017. Goals are also discussed on a monthly basis at the staff meetings.</p> <p>Activities within the quality and risk management programme include health and safety, adverse event reporting, infection prevention and restraint minimisation. There are policies in place that have been reviewed at least two yearly with documentation of links to legislation and evidence. Policies include reference to changes in practice such as interRAI, Health and Safety at Work legislation and pressure injuries. A document control system is implemented.</p> <p>Quality related data and outcomes are collated. There are monthly staff and registered nurse meetings held to discuss issues with documentation in meeting minutes evidencing clinical review and discussion. All aspects of the quality programme are linked to the meetings, including infection control (refer 3.5); complaints; incidents and accidents; goals; human resources and other. Staff interviewed describe understanding and implementing the quality and risk management programme. There are monthly resident meetings and family are able to attend if they wish. There is evidence of discussion and feedback on any areas for improvement identified. Corrective action plans are documented with evidence of resolution of issues.</p> <p>There is an internal audit schedule that is implemented as per documented timeframes. Corrective action plans documented show evidence of resolution of issues.</p> <p>Health and safety requirements are being met, including hazard identification. A substance register identifies hazards associated with chemicals and there are material safety data sheets. Managers, staff, residents and family can describe input into the health and safety programme through relevant meetings and through discussions with the clinical nurse manager or general manager. A health and safety officer is appointed to the service to provide oversight of implementation of the policy.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	<p>FA</p>	<p>There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are being reported.</p> <p>The incident forms completed show evidence of immediate responses, investigations and remedial</p>

<p>the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>actions being implemented as required. Incidents that are unwitnessed or that include an injury to the head show that neurological recordings are taken for a sustained period. The review confirms that documented incidents and accidents are closed mostly in a timely manner with actions taken to address issues raised.</p> <p>The general manager and clinical nurse manager understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. There have not been any incidents that have had to be reported to external authorities since the last audit.</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>	<p>PA Low</p>	<p>There is an established system in place for human resource management.</p> <p>All staff records reviewed include an employment agreement and a position description is on file. Staff do not always have criminal vetting prior to appointment and an improvement is required.</p> <p>Professional qualifications are validated with a current annual practicing certificate on file for registered nurses; the medical officer; physiotherapist and pharmacist. All staff receive an orientation and participate in ongoing education when this is offered. Performance appraisals are completed for all staff who have been employed for 12 months or more.</p> <p>There is a registered nurse in charge on each shift. Files of registered nurses reviewed hold current first aid certificates. Other staff also have a first aid certificate with these including the cook and the diversional therapist. There are two registered nurses training in interRAI and the clinical nurse manager has completed the management component of interRAI.</p> <p>There is an annual training plan that is implemented and attended routinely by most staff. Attendance records are kept for each session with documentation of what is covered in each session. Staff state that they find the training relevant to their roles. Some sessions are facilitated by a registered nurse and at times, there are sessions facilitated by specialists from the district health board or other providers such as Hospice.</p> <p>Medicines are given by registered nurses and caregivers who have been assessed as competent. Staff participate in meetings and confirm that they are kept up-to-date on changes occurring within the service or matters of concern through handover and open dialogue with the general manager and the clinical nurse manager.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>The process for determining provider levels and skill mix is defined in policy and considers the layout facility and levels of care provided. The general manager develops staff rosters. Rosters</p>



<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>and staff interviewed and observation on the days of audit confirmed there were sufficient numbers of staff in each area to meet minimum requirements as specified in the Aged Residential Care Agreement.</p> <p>Registered nurses are on duty each shift and are supported by caregivers including staff who have been working in the service for between one and over ten years. There is a low rate of staff turnover. The clinical nurse manager is on-site Monday to Friday. Staff are rostered onto one of three shifts and allocated to hospital or rest home wings. There are five caregivers on duty in the morning; three in the afternoon as well as a short-shift and one overnight. Acuity and numbers of residents is considered when rostering staff. Rosters reviewed confirmed that there is always a replacement staff member when a rostered staff is on leave.</p> <p>The general manager lives close by and is on call at all times. Staff state that the general manager (or registered nurse if relieving) respond immediately in the event of an emergency.</p> <p>There is a staff member on duty on each shift, with a current first aid certificate.</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>Paper-based resident records are maintained for each resident. All records are maintained confidentially. The resident records are stored in a secure manner. The files record information for ongoing care and support being provided. Records are integrated.</p> <p>A record of past and present residents is maintained. InterRAI assessments are completed by the registered nurses and inform the development of the resident's plan of care. Progress records are clearly documented by the care staff in the paper-based record. The date, time, signatures and designation of those entering into the records is legible.</p>
<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>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a timely and respectful manner. Admission information packs on the services for rest home and hospital level care, are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed were signed by the service and by family or resident. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and</p>	<p>FA</p>	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and</p>

coordinated transition, exit, discharge, or transfer from services.		their families are involved for all exits 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>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses a paper-based medication system. Clinical staff who administer medications; RNs, EN and senior healthcare assistants who have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart. All medication is stored safely in the designated medication areas in the rest home and hospital unit. Medication fridges are maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. Three monthly GP reviews are documented on the medication chart and/or through the GP documentation in the resident's file.</p> <p>There were no residents self-medicating on the day of audit. Standing orders are not used.</p> <p>Fourteen medication charts reviewed (seven rest home and seven hospital level residents) met legislative requirements.</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 service delivery.</p>	FA	<p>All meals at the service are prepared and cooked on-site. The kitchen was observed to be clean and well run. All temperatures were monitored including fridges, freezer and meals on serving. The menu had been reviewed by a dietitian in 2016 and was currently under review. Kitchen staff were trained in safe food handling, and food safety procedures were adhered to. Staff were observed delivering meals and assisting residents with their lunchtime meals as required. Diets were modified as required. Resident dietary profiles and likes and dislikes were known to food services staff and any changes were communicated to the kitchen via the registered nurse. Resident meetings and surveys allowed for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicated satisfaction with the food service. Alternatives are 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,</p>	FA	<p>There is an admission to service 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>

where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools (link to 1.3.3.3 for timeliness of interRAI assessments). Resident needs and supports were identified through available information such as discharge summaries, medical notes and in consultation with significant others. A respite resident did not have an up-to-date assessment and plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Long-term care plans evidenced resident and family/whānau involvement in the care plan process. Relatives interviewed confirmed they are involved in the care planning process. Resident files demonstrate service integration. There was evidence of allied healthcare professionals involved in the care of the resident including: physiotherapist, podiatrist, and dietitian, wound care nurse specialist and older person's mental health services.</p> <p>Resident care plans reviewed did not include all care and support as documented in interRAI assessments, progress notes or other assessments. Short-term care plans are used for changes to health status and sighted in resident electronic files, (eg, infections and wounds). Handovers evidenced that in-depth resident information is discussed to ensure safe care.</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>	FA	<p>There is documented evidence in the progress notes of family/whānau contact in each resident file that indicates family were involved in care planning. Discussions with families confirm they are aware of the care and support provided. The GP confirmed on interview that care interventions are appropriate and that GP instruction is implemented.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. The hospital had four residents with five wounds (skin tears and scratches and one donor site). Three further residents had healed wounds and were included in the wound log to ensure regular checking. In the rest home there were five residents with wounds; one resident with two pressure injuries. Other residents had wounds such as, cracked heels, lesions skin tears and a bunion. There is evidence of the wound nurse specialist involvement in wound management. All residents had documented assessments, wound management plans and evaluations documented.</p> <p>Continence products are identified in resident files and include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring forms are used for weight, vital</p>

		signs, blood sugar levels, pain, challenging behaviour, food and fluid charts.
<p><b>Standard 1.3.7: Planned Activities</b></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 currently employs one diversional therapist and activity coordinator. The programme is planned monthly and activities planned on the day were displayed on noticeboards around the facility. Resident files include a personalised activities assessment and plan. The programme is Monday to Friday and integrated to meet the physical and psychosocial well-being of the residents. The programme includes; outdoor garden activities, including garden walks, poetry reading, exercises for both the less mobile and the more active, a daily walking group (volunteers assist so that residents in wheelchairs can come along). There are regular outings into the community. The service has a van for regular outings. One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated.</p> <p>An activities resident profile is completed on admission. Individual activity plans were seen in long-term resident files. The activity team is involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through monthly resident meetings and direct feedback from residents and families. Residents and families interviewed said the activities programme was very good.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Written evaluations are undertaken using the interRAI tool or updated through the care plan process. The GP reviews the residents at least three monthly or earlier if required. The ACC resident had documented evaluation though the ACC team. Short-term care plans reviewed had been evaluated at regular intervals. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p>
<p><b>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</b></p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>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.</p> <p>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.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The service displays a current building warrant of fitness, which expires on 22 September 2018. The service employs a maintenance person, three days a week. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes six monthly building compliance checks, (eg, hot water temperature, call bells, resident equipment and safety checks). Medical equipment and electrical appliances have been tested and tagged and calibrated. Essential contractors are available 24-hours. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and courtyards on the ground floor. There is a designated outdoor smoking area. Seating and shade is provided.</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>The rest home resident rooms are single rooms with hand basin and toilet in each room. The hospital wing has communal showers and toilets available for residents use. There are communal toilets with privacy locks located near the communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity are maintained while attending to their personal cares and hygiene. The communal toilets and showers are well signed and identifiable and include vacant/in-use signs.</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 spacious. There is adequate room to safely manoeuvre mobility aids or hoists in hospital rooms. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms, which included 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 accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is a large lounge and dining room in the rest home and a smaller lounge and dining room in the hospital wing. Meals are transported in a bain marie. Meals were noted to be well presented and warm at meal times in both the rest home and hospital. There are small seating and lounge areas situated throughout the facility.</p> <p>All areas were easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed reported they are able to move around the facility and staff assist them when required. Activities take place in any of the lounges.</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 policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry persons and cleaning staff on duty seven days a week. The laundry and cleaning staff have completed chemical safety training and laundry processes. Laundry is transported in covered trolleys to the laundry. The laundry has a designated dirty to clean flow. There is appropriate personal protective-wear readily available. The cleaner's trolley is stored in a locked area when not in use. Internal audits monitor the effectiveness of the cleaning and laundry processes.</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>Emergency, disaster policies and procedures are documented for the service. There are emergency flip charts throughout the facility for all emergency disasters. The orientation programme and annual education/training programme include fire, security and emergency/civil defence situations. The fire evacuation scheme has been approved for the rest home and hospital. Fire drills occur every six months. Staff interviewed confirmed their understanding of emergency procedures. There are adequate supplies available in the event of a civil defence emergency including food, external water tank, and gas cooking and heating. A call bell system is in place including all resident rooms and communal areas. Residents were observed in their rooms with their call bell within reach. There is at least one staff member on duty 24 hours a day with a current first aid/CPR certificate. The building is secure after-hours.</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</p>	<p>FA</p>	<p>Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature with central heating, which can be adjusted to meet individual requirements, each room having individual thermostats and temperature controls. The residents and family interviewed confirmed temperatures were comfortable.</p>

maintained at a safe and comfortable temperature.		
<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, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system with infection control reports presented at the monthly staff meeting. A registered nurse (clinical nurse manager) is the designated infection control coordinator. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</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 for the size and complexity of the organisation. The IC nurse was an infection control coordinator for the DHB in her previous role, and has external support from the IC nurse specialist at the DHB. 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 policies and procedures are appropriate for the size and complexity of the service and have been reviewed by the IC coordinator and team. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred and is included in the annual training plan. The infection control coordinator links to the IC team at the DHB. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this</p>

		is documented in their medical records.
<p><b>Standard 3.5: Surveillance</b></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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is reported at the monthly staff meetings. Data and graphs of infection events are available to staff. Trends are identified, analysed and preventative measures put in place.</p> <p>Systems in place are appropriate to the size and complexity of the facility, there have been no outbreaks in the last 12 months.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a policy around use of enablers and restraint. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There are two residents at the service using enablers and three residents using restraint at time of audit (bedrails and one having access to a lap belt if required). There is evidence that staff use strategies to minimise restraint and restraint practices are the last resort.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews. One resident record was reviewed for a resident using an enabler. The review confirms that an assessment had been completed and the care plan referred to the use of the enabler (bedrail).</p>
<p><b>Standard 2.2.1: Restraint approval and processes</b></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>	FA	<p>Lines of responsibility for the restraint process including approval of the use of restraint is documented in the policy. The service has a process for determining approval of the types of restraint used and this is implemented when required. Each record reviewed (two where a resident used a bedrail identified as restraint) included a consent form for the use of the restraint that was signed by the general practitioner, the restraint coordinator (general manager) and the family member.</p>



<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The registered nurse completing the interRAI and care plan completes a restraint assessment prior to commencement of any restraint. Two resident records reviewed confirm that all have an interRAI assessment that refers to the use of restraint and an assessment completed specifically for use of the restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Strategies are implemented prior to use of restraint to prevent the resident from incurring injury. The strategies are documented in the restraint care plan and referenced also in the long-term care plan. Staff and management interviews confirmed knowledge of the strategies documented with these individualised to the resident.</p> <p>Restraint is described as being the last resort. The two files reviewed confirmed that the environment is considered prior to using restraint; that the reasons and desired outcomes for use of the restraint are documented and any alternative interventions of outcomes are considered.</p> <p>A register of the restraint is updated when any new restraint is used or following a reassessment or care plan review.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Each episode of restraint is evaluated for its effectiveness and need of continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters.</p> <p>There is a monitoring form with staff checking to ensure that the restraint is used correctly and that there are no negative outcomes for the resident while the restraint is in use. Staff check four hours or more frequently if required with monitoring forms confirming that these are carried out in a timely manner.</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>The individual resident's restraint reviews and restraint register updates are conducted. Staff interviews confirmed their awareness of the residents who require restraint and the residents who requested the use of enablers. The staff meeting minutes record discussions on restraint. Residents' progress notes evidence restraint is monitored and evaluated at each shift, when in use. The observed handover confirms that any use of restraint is discussed with outcomes of use confirmed.</p> <p>A review of incident forms did not identify any poor outcomes from the use of restraint.</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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>The accident, incident and open disclosure policy states that relatives are to be informed of any incident or accident. The form used to record an incident, accident or near miss allows for documentation of disclosure to family. Twenty-five percent of incidents or accidents in January 2018 and December 2017 did not include documentation as to whether the family had been contacted.</p>	<p>Not all Towards Improving Services (TIS) forms that record incidents and accidents include documentation as to whether family have been informed.</p>	<p>Ensure that relatives are informed of any incident or accident as per policy.</p> <p>90 days</p>

<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>There are policies in place around human resources. These include the need for reference checking and criminal vetting. Two of the seven staff files include evidence of criminal vetting and one has evidence of reference checking.</p>	<p>Not all staff files include evidence of reference checking and criminal vetting.</p>	<p>Ensure that staff are checked through criminal vetting and reference checking.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>The service has two interRAI trained staff. An RN has been dedicated to interRAI assessments as part of the services plan to ensure consistency of assessment and timeliness of assessments. This process has recently commenced and interRAI were not up-to-date at the time of audit.</p>	<p>InterRAI assessments have not been documented according to set timeframes. (i) Two hospital residents did not have an initial interRAI within 21 days; one admitted November 2017 has no interRAI documented and one was four months post admission; (ii) one hospital resident has a gap of eight months between the last and the most recent interRAI, and (iii) one rest home has gaps varying between six to nine months between routine assessments.</p>	<p>Ensure the interRAI assessments are documented according to set timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified</p>	<p>PA Low</p>	<p>The service has processes in place for all new admissions. There are documents, initial clinical assessments and initial/short stay templates in place. Long-term resident files reviewed all had an initial</p>	<p>One respite resident (rest home) assessments and care plan were from the previous admission and not reviewed/updated for this admission.</p>	<p>Ensure that new/re-admission admissions have updated assessments</p>

via the assessment process and are documented to serve as the basis for service delivery planning.		assessment and care plan in place prior to development of the long-term care plan.		and care plans.  60 days
Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	All seven resident files reviewed have a documented care plan in place. Care staff interviewed are very knowledgeable regarding care and support needs for the residents. Both resident's and relatives felt that the care was very good. Care interventions were not documented for all aspects of care.	(1) Rest home: One resident file had a history of weight loss but no interventions to address this, a behaviour management chart was documented for this resident, but there were no interventions for managing challenging behaviour.  (2) Hospital: (i) One resident has a history of weight loss but no interventions to manage this. There were no interventions to manage behaviour that challenges (resistive behaviour, spitting, and wandering) with the care plan documenting 'not applicable'. Other anti-social behaviour had interventions (to close the door), however, the documented high falls risk for this resident was not reflected into the care plan with conflicting care such as wheelchair and independent with mobilising. (ii) One resident had conflicting information regarding 'mood' that documented happy and low mood, with no interventions for low mood. (iii) One resident did not have up-to-date information regarding an indwelling catheter that had since been removed, care and support for smoking and care and support needed for poor field of vision and the need to assist with direction and balance.	Ensure that care plans reflect resident need and provide care interventions to manage care.  30 days

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

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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.

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End of the report.