

Lansdowne Park Village Limited - Lansdowne Park Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Lansdowne Park Village Limited
Premises audited:	Lansdowne Park Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 August 2018 End date: 7 August 2018
Proposed changes to current services (if any):	No
Total beds occupied across all premises included in the audit on the first day of the audit:	63

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Lansdowne Park Village is owned and operated by the Arvida Group. The service provides care for up to 79 residents with 50 dual-purpose beds in the care centre and up to 29 serviced apartments certified to provide rest home level care. On the day of the audit, there were 63 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 a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff, management and general practitioner.

There is a village manager (RN) who has many years' experience managing an aged care facility. The village manager is supported by a clinical team leader in the hospital wings and a clinical team leader in the rest home/serviced apartment wing. Family and residents interviewed all spoke positively about the care and support provided.

The service is implementing the organisations quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. The service has implemented an electronic resident management system.

This audit identified improvements required around incident reporting, coordination of care, care plan interventions, and medication documentation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff at Lansdowne Park Village strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural needs are met. Policies are implemented to support residents' rights, communication and complaints management. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Lansdowne Park Village has a current business plan and quality assurance and risk management plan that outlines objectives for the year. The quality process being implemented includes regularly reviewed policies. Aspects of quality information are reported to the monthly quality committee meeting. There is an annual internal audit calendar schedule. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly resident meetings and via annual resident/relative satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. The service has an orientation programme in place that provides new staff with relevant

information for safe work practice. The in-service education programme for 2018 is being implemented. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. InterRAI assessments are utilised and link to care plans. Resident files included medical notes by the general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. The medicine charts were reviewed at least three-monthly by the general practitioner.

An integrated activity programme is implemented for residents. Residents and families report satisfaction with the activities programme. 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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Lansdowne has a current building warrant of fitness. 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. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with ensuites. 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. All registered nurses hold 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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Lansdowne Park Village has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were six residents with restraints and four residents using an enabler. Assessments and consents were fully completed. The rest home/serviced apartment clinical team leader is the designated restraint coordinator. Staff receive training around restraint minimisation.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	46	0	3	1	0	0
Criteria	0	97	0	3	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with 13 care staff (six caregivers, four registered nurses (RN), two diversional therapists and one activities assistant) confirmed their familiarity with the Code. Interviews with seven residents (three rest home, including one in the serviced apartments and four hospital) and seven families (three rest home and four hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident, staff and quality committee meetings. Staff receive training on the Code, last occurring in July 2018.</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>	FA	<p>Informed consent processes were discussed with residents (as appropriate) and families on admission. Written general and specific consents were evident in the long-term resident files reviewed. Caregivers and RNs interviewed confirmed consent is obtained when delivering cares. Advance directives identified the resident resuscitation status. Advance directives and medically initiated 'do not resuscitate' had been appropriately signed by the resident and general practitioner (GP). Copies of EPOA are contained within the resident file where appropriate. Discussion with seven family members (three rest home, four hospital) identified that the service actively involves them in decisions that affect their relative's lives. A sample eight resident files were reviewed. Signed admission agreements were sighted in the long-term resident files reviewed. General consents were also included as part of the admission agreement.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy, last occurring in July 2018. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. Residents and relatives interviewed confirmed that relative/family visiting could occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. Three complaints have been received at Lansdowne Park Village since the last audit, one was made in 2017 and two received in 2018 year to date. The complaints reviewed have been managed appropriately with acknowledgement, investigations and responses recorded. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service a manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p>	FA	<p>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. There is a policy that describes spiritual care.</p>

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		Church services are conducted regularly. Residents interviewed indicated that resident's spiritual needs are being met when required.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The service has established cultural policies to help meet the cultural needs of its residents. There was one resident that identified as Māori at the time of the audit. The file of the resident that identifies as Māori was reviewed and included a Māori health plan. The Māori resident is the residents advocate around cultural awareness. The service has established links with Kahungunu Ki Wairarapa who provide advice and guidance on cultural matters. Staff interviewed confirmed they are aware of the need to respond appropriately to maintain cultural safety. Cultural safety training was last provided in July 2018.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. Residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include pre-employment and

		<p>the requirement to attend orientation and ongoing in-service training.</p> <p>Arvida is operationalising their vision 'to transform the ageing experience' within the care communities through the introduction of the household model. The household model focuses on the relationship between the care team and the resident as partners in the pursuit of a rich and meaningful life. The emphasis is on supporting each resident to live well and be actively engaged in their life the way they want it to be. Residents are encouraged and supported to create a comfortable living space suited to their particular needs and personal tastes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen incident/accidents forms reviewed for June and July 2018 had documented evidence of family notification or noted if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. Interpreter services are available as required. The service has restructured and appointed three clinical leaders one for Matai and apartments and one for Hospital wings 'Kauri and Rimu' and one village clinical leader with responsibilities as Wellness Leader across the village.</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>Lansdowne Park Village is owned and operated by the Arvida Group. The service provides care for up to 79 residents with 50 dual-purpose beds in the care centre and up to 29 serviced apartments certified to provide rest home level care. On the day of the audit, there were 63 residents in total. There were 44 residents at rest home level (16 rest home residents in the serviced apartments) and 19 residents at hospital level care, including one resident on a health recovery contract and one resident on palliative respite care. All other residents were under the aged related residential care (ARRC) agreement.</p> <p>There is a village manager (RN) who has been in the role for one year. The village manager is supported by a clinical team leader in the hospital wings and a clinical team leader in the rest home/serviced apartment wing. The two clinical team leader roles were introduced when the clinical manager role became vacant in October 2017 and was not replaced.</p> <p>The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Lansdowne Park Village has a business plan for the period from 1 September 2017 to 31 August 2018 and a quality and risk management programme. The business plan is reviewed on a six-monthly basis with the last review occurring on 31 March 2018.</p>

		The village manager has completed in excess of eight hours of professional development in the past 12 months.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	In the absence of the village manager, the two clinical team leaders are in charge. Support is provided by the general manager operations, national quality manager (who was present at the time of the audit) and the care staff.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a business plan that includes quality goals and risk management plans for Lansdowne Park Village. The village manager is responsible for providing oversight of the quality programme on-site, which is also monitored at an organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. Staff interviewed could describe the quality programme corrective action process. The site-specific service's policies are reviewed at least every two years across the group. Head office sends new/updated policies. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement.</p> <p>Resident/family meetings occur three monthly and the residents and family members interviewed confirmed this. Residents/relatives are surveyed annually to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The overall service result for the resident/relative satisfaction survey completed in March 2018 was at 82%. Corrective actions have been established in areas where improvements were identified (ie, food service and activities). Corrective actions were being completed and signed off at the time of the audit. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>Restraint and enabler use is reviewed at the monthly quality committee meeting. Arvida has a group health and safety manager who works with all of the village managers to ensure compliance with all health and safety requirements across the group. Health and safety goals are established and regularly reviewed at the village manager's monthly teleconference meeting. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored at the monthly health and safety committee meeting. Health and safety representative (maintenance person) was interviewed</p>

		about the health and safety programme. All health and safety committee members have completed specific health and safety training. Hazard identification forms and an up-to date hazard register are in place.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A registered nurse (RN) conducts clinical follow-up of residents. Fifteen incident forms reviewed in June and July 2018 demonstrated that appropriate clinical follow-up and investigation occurred following incidents (link 1.3.3.4). However neurological observation forms were not completed as per protocol for five of six unwitnessed falls with potential head injury. Not all falls and pressure injuries in June and July 2018 had an incident form completed. Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications completed 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>	FA	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Eleven staff files were reviewed (two clinical team leaders, two RNs, four caregivers, one diversional therapist, one kitchen manager and one maintenance person). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme.</p> <p>An in-service education programme plan for 2018 is being implemented. The village manager, clinical team leaders and RNs are able to attend external training, including sessions provided by the local district health board (DHB). Discussions with the caregivers and the RNs confirmed that ongoing online aged care training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. Eight of twelve RNs have completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service</p>	FA	<p>Lansdowne Park Village policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 103 staff in various roles. Staffing rosters were sighted and there is staff on duty to meet the resident needs of different shifts. The village manager and the two clinical team leaders all work 40 hours per week and are available on call</p>

<p>from suitably qualified/skilled and/or experienced service providers.</p>		<p>after-hours. In addition to the village manager and clinical team leaders, there is at least one RN on at any one time. The RN on each shift is aware that extra staff can be called on for increased resident requirements. There are dedicated housekeeping and laundry staff. Interviews with staff, residents and relatives confirmed there are sufficient staff to meet the needs of residents. The service currently has 28 rest home residents and 19 hospital residents in the care centre and 16 rest home residents in the serviced apartments.</p> <p>In the hospital wings. (i) Kauri wing, there are 16 residents (11 hospital and five rest home), and (ii) Rimu wing there are 15 residents (eight hospital and seven rest home). A clinical team leader (CNL) is on duty on the morning shift. The CNL is supported by one RN on the morning and afternoon shifts, and one RN on night duty. The hospital RNs are supported by eight caregivers rostered on the morning, six caregivers on the afternoon shift and two caregivers on night duty.</p> <p>In the rest home Matai wing, there are 16 rest home residents. A clinical team leader is on duty in the morning shift and oversees both the rest home and serviced apartments (on first floor). The CNL is supported by one RN on the morning and afternoon shifts. The rest home RNs are supported by three caregivers rostered on the morning, two caregivers on the afternoon shift and one caregiver on night duty. In the serviced apartment's wing, Tawa there are 16 rest home residents. There are three caregivers on the morning shift and two caregivers on the afternoon shift. A caregiver from the rest home supervises the rest home level care residents in the serviced apartments on the night shift.</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>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are electronically stored in the resident management system, and are password protected. Other residents or members of the public cannot view sensitive resident information.</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 competent, equitable, timely and respectful manner. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed align with all contractual requirements and kept within the electronic file. 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 coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Planned exits, discharges or transfers were 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 their families are involved for all exit or discharges to and from the service. Two resident files reviewed included DHB discharge summaries following acute hospital visits.</p>
<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>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs, enrolled nurses and senior caregivers) have been assessed for competency on an annual basis. Annual education around safe medication administration has been provided. Registered nurses complete syringe driver training. Two-weekly delivery of robotic packs are checked against the medication charts by the RNs. The medication fridge is checked daily and maintained within the acceptable temperature range. All eye drops, and ointments sighted were dated on opening. Residents self-medicating are managed according to policy. A three-monthly competency was sighted for one self-medicating resident reviewed. Twenty medication charts were reviewed across the rest home/hospital and serviced apartments. All had photo identification, and had been reviewed by the GP at least three-monthly. 'As required' medication had indications for use. There were medication documentation gaps identified.</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>	<p>FA</p>	<p>Lansdowne has a commercial kitchen where all food is prepared and served. The service employs two chefs and six kitchenhands. All have completed food safety certificates. The chef interviewed explained the procurement of the food and management of the kitchen. The service has a verified food control plan 14 June 2019.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge, food, freezer, chiller and dishwasher temperatures were monitored and documented daily and were within safe limits.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. Special diets were noted on the kitchen noticeboard.</p> <p>The menu is a four-weekly seasonal menu. Residents and families interviewed, overall stated satisfaction with the food. The service implemented corrective actions around the food service following their last satisfaction survey. Dietary supplements are available. The dietitian reviewed the menu June 2018.</p> <p>Food is served directly through the serving hatch from the bain maries in the main kitchen to the large dining room. Food is covered and transported on trolleys from the main kitchen to the serviced apartment</p>

		kitchenette and to the small dining room in the rest home. A number of residents prefer meals in their rooms and that is resident choice.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The RN completes an initial assessment on admission including risk assessment tools. A long-term care plan is completed within 21 days of admission and thereafter six-monthly, or earlier due to health changes. All long-term resident files reviewed identified interRAI assessment notes and summaries were available. The outcomes of assessment tools are linked to the long-term care plan. The resident needs, goals and supports are documented in the long-term care plans. One hospital resident on end of life contract included assessments completed on admission and completed as needed as the care plan was updated following changes of health status. One resident on palliative respite did not have any assessments or care plan completed on admission (link 1.3.5.2).
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	Resident care plans reviewed (electronic) were overall resident-focused and individualised. A range of assessments including interRAI have been completed and linked to care plan interventions. Overall long-term care plans evidenced updates to care plans as changes to resident's health occurred. The two short-stay residents (one on palliative respite and one on a health recovery contract) did not have all documentation complete. These were addressed during the audit. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. There was evidence of allied health care professionals involved in the care of the resident including the GP, physiotherapist, mental health team, podiatrist, hospice and dietitian.
<p>Standard 1.3.6: Service Delivery/Interventions</p>	FA	When a resident's condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence in the electronic file that evidences family were notified of

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>any changes to their relative's health including (but not limited to): accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Pain charts were in use for residents on PRN pain control medication.</p> <p>There has been increased nurse specialist support through referral to Geriatric Nurse specialist, Respiratory Nurse specialist, Wound Nurse Specialist.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. A sample of 15 wounds records were reviewed including the three pressure injuries (one grade I, two grade II). Wound assessment and management plans, including evaluation notes were in place, however not all fully completed (link 1.3.3.4). The service can access the DHB wound nurse specialist if required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. There is dietitian involvement where required.</p> <p>Monitoring occurs for weight, blood pressure, blood sugar levels, pain, neurological observations, food and fluid charts. These were sighted across the files reviewed. The RN monitors and reviews the monitoring forms daily on the electronic system. Care staff report any changes to the RN (link 1.3.3.4).</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a team of four activity staff (two diversional therapists and two recreation assistants). There are activities scheduled across five days.</p> <p>The integrated programme offers choice and variety of activities for residents to attend including, crafts, board games, card games, newspaper reading, exercises indoors and outdoors and bowls. There are two different planners that go up on the noticeboards in all areas and residents also get an individual copy.</p> <p>There are a number of one-on-one activities for residents not involved in group activities. There are a number of resident-led groups including card group, knitting group, and village choir. There is a van that goes out regularly and includes outings mainly for rest home/serviced apartment residents.</p> <p>Community visitors to the facility include (but not limited to) entertainers and regular interdenominational and Catholic church services. Rest home residents in the serviced apartments are invited to participate in the activities in the care centre. Individual leisure activity plans were seen in all resident files reviewed. The service receives feedback and suggestions for the programme through resident meetings and surveys. Residents interviewed were happy with the activity programme.</p> <p>Arvida is operationalising their vision 'to transform the ageing experience' within the care communities</p>

		<p>through the introduction of the wellness/household model. The wellness/household model focuses on the relationship between the care team and the resident as partners in the pursuit of a rich and meaningful life. Lansdowne has introduced the wellness/household model and is working towards fully implementing the model. There is a wellness meeting and a resident delegate attends. The introduction of the wellness meeting has given the residents a strong voice into how the facility should be run and they provide feedback in the activity programme. The diversional therapists complete an activity assessment on admission and develop/have input into two sections of the electronic care plan 'in leisure and pastoral care'. The service has implemented improvements to the activity programme following the last satisfaction survey. They have increased activity staff hours and family forums and resident's meetings (although hospital resident meetings have been limited).</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>InterRAI re-assessments have been completed six-monthly in support of reviewing the care plan. All care plans have been updated and transferred to the electronic programme over the last 10 months. Each section of the care plan is evaluated as care needs change and six-monthly. Advised that written evaluations will be documented on the electronic programme at the next care plan review. Family are invited to attend the six-monthly MDT review and informed of any changes if unable to attend. The MDT meeting (now called Case Conference checklist on the electronic system) includes a holistic evaluation of care and support including input from allied health and medical staff. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes and long-term care plans updated or short-term care plans established. Changes to the electronic long-term care plan identify name and date to reflect the update. Residents and relatives interviewed confirmed involvement in the Case Conference and evaluation of the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</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. 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. Safety datasheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored safely and secure 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. Staff have completed chemical safety training. There is a secure sluice in the care centre and a small laundry in the serviced apartments. Spill kits are set up for use when needed.</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 building has a current building warrant of fitness that expires 20 November 2018. The service employs a full-time maintenance person who is on call 24/7 for any maintenance issues. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained that includes internal and external building maintenance. The maintenance person has been certified to conduct electrical testing which is completed two yearly. An external contractor completes annual calibration and functional checks of medical equipment.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver resident cares. Hot water temperatures in resident areas are monitored and maintained below 45 degrees Celsius. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to mobilise safely within the facility. There is a lift between floors which is large enough for a stretcher as needed. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating and gardens. There is a pond situated behind the community centre. The pond is visible by staff and residents within the village. There have been no incidents of residents wandering near the pond.</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</p>	FA	<p>All resident rooms in the care centre on the ground floor have full ensuites. Communal toilets are located closely to communal areas. A large shower room situated in the hospital includes a shower trolley. All serviced apartments on the first floor have a full ensuite. Toilet and shower facilities are of an appropriate design to meet the needs of the residents. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant and locks are on doors.</p>

hygiene requirements.		
<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	All rooms are single and personalised. The care centre is designed in four wings (households). There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms. This was evident on the day of audit.
<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>	FA	There is a large communal lounge and smaller lounges/sitting areas in each wing for quieter activities and visitors to give more of a smaller household feel. There is a large main dining room and a smaller dining area off the rest home wing. There is also an open plan dining area for the serviced apartment residents including rest home residents on the 1st floor. There is a large activity room for activity groups and church services. Seating and space in the main lounge is arranged to allow both individual and group activities to occur. All communal areas are easily accessible for residents to assist using mobility aids or with staff assistance.
<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>	FA	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry staff seven days a week. There are defined clean/dirty areas in the laundry with an entry and exit door. Residents and family interviewed, reported satisfaction with the cleaning and laundry service. Internal and external audits monitor the effectiveness of the cleaning and laundry processes. Dirty laundry trolleys in the wings are covered. The cleaning trolleys are well equipped and stored safely when not in use.
<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>	FA	<p>There is an emergency and disaster management plan in place to ensure health, civil defence and other emergencies are included. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service on 16 November 2012. Six monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 14 June 2018. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility.</p> <p>There is sufficient water stored in a water tank. There is adequate food supply, gas cooking (BBQ and gas hobs in the kitchen). Civil defence supplies are available in the event of an emergency (checked every six months). There is a generator available on-site if there is a power failure. Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid and</p>

		cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The underfloor heating throughout the facility is centrally controlled. There are overhead heating/cooling air conditioning systems in the lounges. The residents and family interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months.
Standard 3.1: Infection control management 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.	FA	The infection prevention and control officer role is undertaken by a registered nurse with support by the village manager (RN). There is a job description that outlines the responsibility of the role. The infection prevention and control officer is supported by the combined quality committee, which also acts as the IC committee. Infection control data is reported to staff and management including head office. The infection control programme has been reviewed annually at the head office by the general manager wellness and also through the quality committee last reviewed 4 August 2018). Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. The service has increased placements of hand sanitiser since previous audit. Residents are offered the annual influenza vaccine. There have been no outbreaks since previous audit. An outbreak management cupboard and trolleys has been implemented as a quality initiative.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection prevention and control officer and village manager has completed the MOH online training. The quality committee (which includes infection control) includes representatives from each area. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection prevention and control officer and quality committee have good support from the Arvida Group head office, the infection control nurse specialist at the DHB, external consultants, laboratory technician and GPs.
Standard 3.3: Policies and procedures Documented policies and	FA	There are Arvida Group infection control policies and procedures that are appropriate for the size and complexity of the service. The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and

<p>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>		<p>training and education of staff.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<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 annually and was last completed by an IP&C nurse from the DHB September 2017. Hand hygiene audits are completed as part of the internal audit programme. All staff complete infection control orientation and questionnaires on employment. Information is provided to residents that is appropriate to their needs and this is documented in clinical records.</p>
<p>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.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida Group infection control manual. Monthly infection data is collected for all infections based on standard definition of signs and symptoms of infections. Surveillance of all infections is entered into the monthly online infection control register. Head office can monitor current infections. This data is monitored and evaluated monthly, six-monthly and annually. Trends and analysis of infections and corrective actions are discussed at the quality committee meetings. Meeting minutes and graph are available to all staff. Benchmarking occurs within the Arvida Group.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were six residents with nine restraints (four bedrails, one lap belt and four chair briefs) and four residents with an enabler (bedrails). Enabler use is voluntary. Assessments and consents were in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint has been discussed as part of quality committee meetings. Staff receive training around restraint minimisation.</p>

<p>Standard 2.2.1: Restraint approval and processes</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>The rest home/serviced apartments clinical team leader is the designated restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.</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>	FA	<p>Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. The service completes assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whānau.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. Monitoring forms included regular two hourly monitoring. The service has a restraint and enablers register, which was up to date.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation is required to include the areas identified in 2.2.4.1 (a) – (k). Evaluations are to be completed by the restraint coordinator at least three monthly or earlier if required. Four resident files identified a current evaluation. The case conference (MDT six-monthly review) also includes a review of restraint use with the family.</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>	FA	<p>Restraint usage is monitored regularly by the restraint coordinator. Corrective actions are monitored. Restraint is discussed at the quality committee meetings. Individual restraint use is monitored and recorded by staff.</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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	Fifteen incident forms reviewed for June and July 2018 demonstrated that appropriate clinical follow-up and investigation occurred following incidents. However neurological observation forms were not completed as per protocol for five of six unwitnessed falls with potential head injury. There is an accidents and incidents reporting policy in place however not all falls and pressure injuries were being reported.	i) Fifteen accident/incident forms were reviewed in total. Six of the fifteen accident/incident forms reviewed were for resident unwitnessed falls with a potential head injury. There was no documented evidence for five of the six neurological observations being completed as per the policy requirement; ii) There was no documented evidence that eight falls and two pressure injuries identified in June and July 2018 had an accident/incident form completed.	<p>i) Ensure that neurological observations forms are fully completed for any resident fall with a head injury as per the policy requirement. ii) Ensure that incident forms are completed for any falls and pressure injuries that occur.</p> <p>90 days</p>
Criterion	PA	The service uses robotic packs that	The following medication documentation shortfalls were	Ensure medication

<p>1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>Moderate</p>	<p>are reconciled on arrival to the facility. All medication is stored in a locked treatment room. Twenty medication charts were reviewed across the service. Shortfalls were identified across medication documentation.</p>	<p>identified across the 20 medication charts reviewed. (i) Pharmacy generated medication signing sheets includes all medications and not just those in the robotic pack. Therefore, not all non-packed medications such as eyedrops were signed for separately. (ii) One resident had two charts (one faxed, one other). It was difficult to determine which is the current chart and leva dopa included different administration times charted on each chart. (iii) Two INR forms included instructions from the lab for administration of warfarin. These were not signed by the GP. (iv) Charting abbreviations used by the GP on one medication chart (2° and 4° PRN pain relief) could not be interpreted by the RN interviewed. (v) One rest home resident was charted codeine 4x daily (and PRN), but this was not in the robotic pack.</p>	<p>documentation meets legislative requirements and medication guidelines.</p> <p>30 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Low</p>	<p>The electronic files reviewed identified integration of allied health and a team approach was evident, however progress notes were not consistently completed by registered nurses to evidence follow up when resident health status changes. Staff interviewed could describe a verbal and written handover. Progress notes are mainly completed by registered nurses with care staff completing the daily ADL records. Wound assessment/management and evaluations are maintained on the electronic system; however, documentation was not fully completed.</p>	<p>(i) Progress notes reviewed in eight resident files identified, after incidents/accidents and changes in health status, RNs did not always document follow-up on consecutive shifts. (ii) A serviced apartment resident file reviewed identified needs assessments identifying resident was reassessed as hospital level care without the service being aware (this was followed up with a dispensation from HealthCERT during the audit). (iii) Wound assessment and management plans were incomplete for one resident with a grade II sacral pressure injury.</p>	<p>(i) Ensure progress notes reflect follow-up and ongoing assessments for residents where there is a change of health status identified. (ii) Ensure documentation is updated to reflect the residents needs/current level of care. (iii) Ensure wound assessments and management plans are fully completed for all</p>

				current wounds. 90 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Resident care plans reviewed (electronic) were overall resident-focused and individualised. However, four of eight care plans did not include interventions to support all current assessed needs. Interviews and documentation reviewed identified implementation of required care and therefore the risk has been identified as low.</p>	<p>Four of eight care plans did not include interventions to support all current assessed needs; (i) Hospital resident on palliative respite did not have a care plan in place on admission. This was addressed during the audit; (ii) The care plan for a hospital resident on a Health Recovery contract did not include interventions specifically around supporting the resident to manage alone at home; (iii) Two residents (one hospital and one rest home) did not have any interventions to support skin integrity and management.</p>	<p>(i) Ensure care plans are in place on admission to support all respite residents. (ii) Ensure interventions are documented to support all assessed needs.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.