Bupa Care Services NZ Limited - Gladys Mary Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Gladys Mary Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 25 October 2018 End date: 26 October 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 34

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

Gladys Mary is part of the Bupa group and provides rest home and dementia level of care for up to 39 residents. On the day of audit, there were 34 residents.

The service is managed by a facility manager who is non-clinical. He is supported by a clinical nurse manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed one of two shortfalls from the previous certification audit around medication documentation. Improvement continues to be required around training.

This surveillance audit also identified further improvements required around open disclosure, self-medicating and care plan evaluations.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.

The rights of the resident and/or their family to make a complaint are understood, respected and upheld by the service. Evidence of communication is documented in the family/whānau communication record on the resident file.

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 medium or high risk and/or unattained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. The facility manager and clinical nurse manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. Corrective actions are implemented where opportunities for improvements are identified. A risk management programme is in place, which includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are documented in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. There is a Bupa annual education

schedule documented and staff are required to complete annual competencies. Staffing levels are adequate to meet the needs of the residents.

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 low risk.

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, develops care plans and evaluates outcomes and goals. There is evidence of resident and/or family/whānau input. Care plans reviewed in resident records demonstrated service integration and the care plans were reviewed at least six monthly.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete education and medication competencies. The medicine charts were reviewed at least three monthly.

There is a varied activity programme which is delivered on-site by an activities coordinator. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each consumer group. Residents and families reported satisfaction with the activities programme.

All food is cooked on-site, and residents' nutritional needs are identified and documented, and choices are available and provided. Meals are well presented. Nutritional snacks are provided over 24 hours.

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.

The building holds a current warrant of fitness.

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.

Enablers are voluntary and the least restrictive option. There were no residents with enablers or restraints.

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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator uses the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility. The service engages in benchmarking with other Bupa facilities.

Summary of attainment

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

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	12	0	3	1	0	0
Criteria	0	37	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. A record of two written complaints has been maintained by the facility manager using a complaints' register in 2018. Documentation included follow-up letters, information relating to the Health and Disability Advocacy Service and resolution demonstrating that complaints are being managed in accordance with the Health and Disability Commissioner Code of Rights. Corrective actions were implemented as a result of the complaints. There were no documented complaints in 2017 according to the register. Discussions with two residents (rest home level) and three relatives (one of whom was the complainant in one of the complaints), confirmed they were provided with information on complaints and complaints forms. Complaints forms are displayed in a visible location at the entrance to the facility. The complainant interviewed, stated she was very happy with the process and commented that management were professional and helpful. The service has one HDC complaint received early 2018. Documentation related to this complaint is kept at head office. Advised this complaint has been closed out. The Ministry requested follow up against aspects of this complaint that included human resource management, service provision requirements and service delivery/interventions. This audit has identified issues with human resource management in particular training and education (link 1.2.7.5).

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	Policies and procedures relating to accident/incidents and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is to be recorded on the family/whānau communication record and accident/incident forms. Ten accident/incident forms reviewed from August 2018 (seven dementia level of care and three rest home care) evidenced that family were not consistently notified. Admission information details next of kin wishes regarding notification of accidents/incidents. Three relatives (two rest home and one dementia care) stated they were notified of any changes to the resident's health including incidents/accidents. An interpreter policy is in place. Interpreter services are used where indicated. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they are to pay for that are not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Bupa Gladys Mary is able to provide care for up to 38 residents at rest home and dementia levels of care. On the day of the audit there were 24 rest home level residents and 10 residents living in the secure dementia unit. All residents were on the ARCC contract. A vision, mission statement and objectives are in place. Annual goals for the facility were determined in January 2018, which link to the overarching Bupa strategic plan. Goals include, (but are not limited to), falls reduction and safe manual handling and reducing the rate of respiratory infections. Progress towards meeting the goals are reviewed regularly and recorded. The facility manager has been in the role for four months (he has been with Bupa for two years and prior to that in hospital management for many years). The facility manager is supported by a clinical manager/registered nurse who has been nursing for twenty-five years with ten years in aged care (two years in the current role). The management team are supported by a regional operations manager and at head office the quality and risk team. The facility manager has maintained over eight hours annually of professional development activities relating to managing an aged care service, which includes orientation to the current role and attendance at Bupa manager days, one in 2017 and one since commencement in current role. He is booked for health and safety training 2018.
Standard 1.2.3: Quality And Risk Management Systems	FA	A quality and risk management programme is in place. Interviews with the facility manager, clinical manager, registered nurse and staff (three caregivers, one activities coordinator, one laundry person and one cook) reflected their understanding of the quality and risk management systems that have been put into place. Policies and procedures and associated implementation systems provide a good level of assurance that the facility

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed by the policy consult group. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents' falls, infection rates, complaints received, restraint use, pressure injuries, wounds, and medication errors. An annual internal audit schedule was sighted. During the period of change of management at the facility, the Bupa internal audit programme had not been fully adhered to (identified at the Care Home Health check September 2018). For the months of May, June, July and August 2018 not all internal audits had been undertaken as per the organisations audit schedule. The audits had subsequently been undertaken with the exception of medication management, multi-disciplinary review and weight management which had been rescheduled to be done. The corrective action plan arising from the Care Home Health check September 2018 which had a number of actions relating to clinical issues was being worked through. The Clinical Lead for Bupa Quality Assurance and the Operation Manager were on site the week of audit assisting in the completion of corrective actions. As part of the corrective actions identified following the HDC complaint Bupa confirmed they would complete three monthly care home health checks, three clinical file audits and ongoing follow up with staff. There is documented evidence the service has commenced three-monthly care home checks. The clinical file audits have been undertaken with the dementia files last achieving 74% and rest home files 77%. Actions to address shortfalls were included in the corrective action plan. The next clinical file audit is due before the end of October 2018. Quality data is benchmarked against other similar Bupa facilities. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are being implemented and signed off by the facility manager when completed. Falls prevention strategies are in place that includes the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. The service has continued with the continuous improvement project of falls reduction. Data indicates the reduction of falls is ongoing. The service has a health and safety committee that provides timely reports regarding health and safety matters. Hazard identification forms and a current hazard register are in place.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically	FA	Individual reports are completed for each incident/accident with immediate action and timely assessment undertaken by a registered nurse (RN). Appropriate monitoring has been completed including neurological observations following unwitnessed falls and/or falls with head injury. Ten accident/incident forms (seven dementia care and three rest home) were reviewed. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. In two of ten accident/incident reports there was no evidence that family had been notified (link 1.1.9.1). The facility manager is aware of their requirement to notify relevant authorities in relation to essential notifications.

recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		Advised that nil notifications had been made since previous audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	There are human resource policies in place, including recruitment, selection, orientation and staff training and development. Five staff files that were randomly selected for review (one clinical manager, two caregivers, one cook and one activity coordinator) included evidence of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed stated that new staff are adequately orientated to the service. An education and training programme is in place for staff. During the period of management change the Bupa education programme had not been fully adhered to, however this had been identified and with the support of head office staff a corrective action plan had been implemented and progress was being made on actions (on the second day of audit, nine staff were attending a full day of education covering Cultural awareness and Maori Health, Communication, Code of rights and Advocacy and Accident & Incident reporting, Open Disclosure and Privacy and confidentiality. Not all mandatory training has been completed in the last two years. The clinical nurse manager and registered nurse are both interRAI trained. In 2018, the clinical manager had undertaken training in pain assessment and management, the admission process and the complaints process. The Bupa regional manager is working with and monitoring the performance of the management team. Not all caregivers (eleven) working in the secure dementia unit have completed the required dementia unit standards. The previous finding relating to meeting contractual requirements of education for secure dementia staff has not been fully addressed.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably	FA	The staffing levels meet contractual requirements. The clinical manager and registered nurse work forty hours per week each Monday to Friday and share on call. Interviews with the residents and relatives confirmed staffing overall was satisfactory. Caregivers interviewed stated there was sufficient staff and the registered nurse or clinical manager were available when needed. In July 2018 an additional 20 registered nurse hours had been added to the weekly roster and additional 20 carer hours per week. The carer roster is as follows; -

qualified/skilled and/or experienced service providers.		Dementia unit (10 residents); two caregivers on am shift and pm shift and one caregiver on night shift. Rest home (24 residents); one caregiver on 7-3pm, one caregiver 7- 12.30pm. On the afternoon shift there was one caregiver 3-11pm, one caregiver 4-9pm. There is one caregiver overnight. On the weekends an additional carer has been added 7am to 12 pm to cover both units as required. The clinical manager and registered nurse work forty hours per week each Monday to Friday and share on call.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication reconciliation including checking of signing sheets is completed on delivery of medications by the RN. There are regular checks of non-packaged medications for expiry dates. There were no expired medications on the day of audit. Ten medication charts reviewed evidenced that all 'as required' medications charted had an indication for use. Previous findings around medication charting of PRN medications and signing for the administration of nutritional supplements have been addressed. However, a shortfall was completed in relation to competency checking of a resident self-administering. A six-monthly pharmacy controlled drug check was completed on the day of audit. All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be compliant in the administration of medications. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at Gladys Mary are prepared and cooked on-site. There is a four-weekly summer/winter menu which had been reviewed by a dietitian. Meals are served directly from the kitchen to the rest home dining area and in a bain marie to the secure unit. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met. Staff were observed assisting residents with their meals and drinks in the dementia unit and rest home as required. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge, freezer and chiller temperatures are taken and recorded daily. End-cooked food temperatures are recorded on each meal. The dishwasher is checked regularly by the chemical supplier. There is evidence of additional nutritious snacks available over 24 hours in the dementia unit. All food services staff have completed training in food safety and hygiene and chemical safety.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required, GP consultation. All long-term care plans reviewed, evidenced that interventions are fully recorded and align with the resident's assessed needs. Short-term care plans are utilised for short-term care issues including changes in health conditions, infections and wounds. Progress notes reflected RN assessments and observations related to changes in health. Long-term care plans sampled had been updated to reflect the resident's current health status. Family members stated they were informed on changes to the resident's health and their relative's needs were being met. The residents and families interviewed were complimentary of the care provided. Wound assessments, treatment and evaluations were in place for all current wounds, (one skin tear, one chronic wound, one ulcer and one surgical wound). There were no residents with pressure injuries on the day of audit. Adequate dressing supplies were sighted in the treatment room. Staff receive regular education on wound management. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for use. Specialist continence advice is available as needed and this could be described by the care staff interviewed. The care staff interviewed stated that they have all the equipment referred to in the care plans and necessary to provide care. The resident files sampled evidenced involvement of referral to allied health and specialist services as required. The registered nurses were involved in a local palliative care group and there was evidence of input from the diabetes nurse from the medical practice and a clinical pharmacist who was undertaking a review on-site at time of audit.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	An activity coordinator works 32 hours a week, Monday to Friday, across the rest home and dementia areas. The activities coordinator is currently undertaking the diversional therapy qualification. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia unit. Care staff provide diversional activities out of normal hours. On the day of audit, residents in both areas were observed being actively involved with a variety of activities with support and involvement of the care staff. The programme is developed monthly, and a weekly programme is distributed and displayed throughout the facility. An activity profile and "Map of Life" is completed on admission in consultation with the resident/family (as appropriate). Activity plans were sighted in the files sampled and these were reviewed six monthly at the same time as the care plans. Activity participation sheets were also maintained. Resident meetings were held monthly, and residents reported that actions were undertaken promptly to matters they

		raised. The service also receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families. The residents and families interviewed spoke positively about the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Long-term care plans had been reviewed at least six monthly in all long-term resident files sampled or earlier for any health changes, however, written evaluations were not documented to evidence residents progress. The multidisciplinary team (MDT) including the GP are involved in the care plan reviews. The GP reviews the residents at least three monthly or earlier if required. Care plans evidenced that changes in health status were documented and STCP's were being utilised.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Gladys Mary displays a current building warrant of fitness, which expires on 17 November 2018. Reactive and preventative maintenance is completed. The external areas and gardens are maintained. There is outdoor furniture and seating and shaded areas. The dementia unit has a safe indoor and outdoor environment with a patio, seating, shade and gardens.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Infections are documented on a monthly register (group electronic system) and also infection data is checked on the electronic medication system. A monthly report is completed by the infection control coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and staff meetings. Benchmarking occurs against other Bupa facilities. There have been no outbreaks since the previous audit.
Standard 2.1.1:	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS

Restraint minimisation Services demonstrate that the use of restraint is actively minimised.		8134.0. The policy includes comprehensive restraint procedures. The registered nurse is the restraint coordinator. Interviews with the caregivers confirmed their understanding of restraints and enablers. Staff attend challenging behaviour and dementia care education annually. At the time of the audit there were no residents using enablers or restraints.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Accident and incidents are logged into the Bupa electronic system. Ten accident/incident forms reviewed from August 2018 (seven dementia level of care and three rest home care) evidenced that family were not consistently notified.	Two of ten incident forms reviewed identified that next of kin (NOK) had not been notified. There was no documented record of why they were not notified.	Ensure documentation reflects that NOK have been notified of incidents/accidents unless requested otherwise. 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing	PA Moderate	An education plan is provided by Bupa head office, covering required education to meet contractual and legislative requirements. According to the education register reviewed, the only training in 2017 had been Fire Safety and Fire Drill. In 2018 to date of audit the following had been undertaken; - Safe food handling; Restraint free environment (12 attended); pain assessment & management (RNs attended); Chemical safety (5	(i)Two of eleven staff working in the secure dementia unit had been in their roles for over three years but had not attained dementia unit standards. The previous finding	(i)All care staff working in the secure dementia unit are to hold/attain dementia units within 18 months of commencing work in the unit. (ii) Ensure all mandatory

education for service providers to provide safe and effective services to consumers.		attended); Continence management (6 attended); Dementia (4 attended); Falls prevention (seven attended); Fire safety and drill (22 attended); First Aid; Moving and Handling (17); Infection control (9); Admission process and care planning (RNs attended). A Person first - dementia second group of four has been established (April 18) and this group were continuing with an hour's study a month. An additional education session was held in May 2018 - it was a debrief of the complaint that had been received, five attended.	relating to dementia education has not been addressed. (ii) Training around de-escalation and managing behaviours that challenge, end of life care and pressure injury prevention and management has not been completed in the last two years.	training is completed. 90 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	There was a policy in place addressing what was to occur if a resident was self-administering. There is currently one resident self-medicating, a three-monthly competency has not been completed.	The policy covering self-administration stated a competency assessment is to be undertaken three monthly. There was no evidence that after the initial competency check that a full competency is being undertaken three monthly for the one resident who was self-medicating.	Ensure a three-monthly competency is completed for the resident self-medicating 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response	PA Low	Care plans had been reviewed six monthly. However, evaluations were not documented to reflect progress towards meeting goals or interventions.	Care plan evaluations were not documented to reflect resident's current status or in meeting goals.	Document a care plan evaluation to determine the effectiveness of care interventions prior to replacement/continuation of long-term care plan. 60 days

to the support and/or intervention, and progress towards meeting the desired outcome.				

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.