

Graceful Home No.2 Limited - Shelly Beach Dementia

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 HealthShare 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: Graceful Home No.2 Limited

Premises audited: Shelly Beach Dementia

Services audited: Dementia care

Dates of audit: Start date: 10 February 2020 End date: 10 February 2020

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: 8

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

Graceful Home No.2 Limited - Shelly Beach Dementia provides dementia level care for up to 14 residents with an occupancy of eight residents on the day of the audit.

This was the second unannounced surveillance audit conducted during the certification period. The audit included a subset of the relevant Health and Disability Standard and the contract with the District Health Board and follow up on previously identified areas requiring improvement. The audit process included a review of the quality and risk management system, review of resident and staff files, interviews with management, family members, one resident and the general practitioner. The owner/director was not available for interview during the audit.

The organisation has made a number of improvements since the last audit. There are now six areas which require an improvement, four of which were identified in the last audit and are yet to be fully implemented and two new improvements identified during this audit. Improvements are now required regarding the registered nurse/clinical manager's position description, risk management, interRAI assessments, clinical observations, a food control plan and environmental restraint.

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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Open communication between staff, residents and families was promoted. Staff were aware of the residents' method for communicating. There is access to interpreting services if required. Systems are in place to ensure family are provided with appropriate information to assist them make informed choices on behalf of the resident. There are both formal and informal processes for family members to voice any concerns or make a complaint. There have been no formal complaints received in this certification period.

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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Organisational performance is monitored. There is a documented business and quality plan. Policies and procedures are current. A range of quality activities are implemented and monitored. Quality data is analysed. Internal audits are completed as required. Management and staff meeting minutes sampled confirmed that quality data regarding service delivery is discussed and monitored. Adverse events are documented and followed up as required. Corrective actions are developed. There are implemented processes for human resource management and rostering.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Resident files sampled confirmed that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health services as required.

The planned activity programme is suitable for the residents and provides residents with a variety of individual and group activities and maintains their links with the community.

There is a safe medication management system in place managed by competent staff.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Snacks and drinks are available for residents on a 24-hourly basis.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There have been no changes to the facility since the last audit. The current building warrant of fitness and approved fire evacuation plan were sighted.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Shelly Beach Dementia has processes in place for restraint minimisation and safe practice. The facility is secure, and on the day of audit there were no residents requiring the use of restraint or enablers. Staff interviewed demonstrated a good understanding of restraint and enabler use. Restraint is part of orientation and training is provided annually or as necessary.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control surveillance programme is implemented and appropriate to the size and scope of the service.

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	10	0	6	0	0	0
Criteria	0	32	0	6	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints management process. The duty leader/facility manager reported that there have been no external complaints to the Health and Disability Commissioner, the district health board or from other external agencies since the last audit. There is a complaint register, however there have been no recorded complaints. The last formal complaint on the register was in 2016.</p> <p>The complaints process is discussed with the resident and family members on entry. An outline of the complaint's procedure is also included in the resident agreement.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>The duty leader/facility manager and registered nurse/clinical manager reported that the owner/director is approachable and open to any discussions regarding the care and support of residents, and any concerns reported by family. There was evidence in resident records that family have been contacted in the event of an incident, or a change in the residents' wellbeing. Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented.</p> <p>Access to interpreter services is available through the district health board if required. There were no residents who required interpreter services at the time of the audit. Staff were observed engaging with residents in a way that appeared effective. Staff understood resident communication cues for those who have difficulty with verbal</p>

<p>conducive to effective communication.</p>		<p>communication.</p> <p>The residential agreement contains descriptions of the services to be provided for subsidised residents. This meets district health board requirements. Resident agreements are signed by the residents EPOA on entry and were sighted in resident files sampled.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Low</p>	<p>The organisation is governed by the sole director who is supported by a business partner who provides financial support, a personal assistant, the deputy lead/facility manager and the registered nurse/clinical manager. The owner/director owns two other rest homes and has been working in the aged care sector since 2010. The organisation is a current member of the Care Association of NZ (CANZ) and the owner/director delegates attendance to cluster group meetings to the deputy lead/facility manager or the registered nurse/clinical manager.</p> <p>The owner/director has an office at one of the other rest homes. The owner/director is actively involved in operational management across the three facilities. The owner/director is on site weekly to catch up with the team.</p> <p>The deputy lead/facility manager is onsite Monday to Friday business hours. The deputy lead/facility manager is supported by a registered nurse/clinical manager who was appointed in June 2019. The previously identified area of improvement regarding delegations, responsibilities and authorities for the senior team still requires further improvement.</p> <p>The owner/director owns the business but does not own the facility. Shelley Beach Dementia can provide care for up to 14 residents requiring rest home - dementia level of care. There were eight residents at the time of the audit. Day care respite services are also provided. These are part funded by the district health board. There were no clients accessing respite services at the time of the audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>PA Low</p>	<p>There has been a number of improvements to the quality and risk management system since the previous audit. Policies and procedures are purchased from an external consultant. The previous area of improvement regarding the currency and control of policies and procedures has been addressed. A 'provision of effect' programme plan has been documented. This includes business goals and objectives for 2019 and 2020 including consumer focus, compliance and a large component of risk management strategies. Records of meeting minutes sampled confirmed that quality related data is now being routinely discussed. For example, staff meetings, which are attended by owner/director, include discussions regarding complaints and compliments, resident outcomes, adverse events, health and safety, internal audits and staff training. Infection control surveillance data is also collated and analysed. There was also some evidence that corrective actions are being developed if a gap in service delivery is identified. The internal audit programme has been reinstated. Quality and risk management is included in the staff orientation. Further corrective actions remain regarding the risk management programme.</p>

principles.		
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Incident and accident prevention, management and reporting policies/procedures are in place. Incident records were tracked to confirm that the required processes are being followed. There was evidence that emergency actions were implemented. Refer to standard 1.3.6 regarding clinical observations following an incident. Investigation and monitoring of the adverse event process remains the responsibility of the registered nurse/clinical manager. The previously identified area of improvement regarding essential notifications to the Ministry of Health and records of events has been addressed.</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>Policies and procedures in relation to human resource management are documented. The process for recruitment, orientation and training was confirmed. The required recruitment activities are shared between the administrator, who has an office at one of the other sites, and the deputy lead/facility manager. Once records of criminal vetting and reference checks are completed, these are required to be forwarded to Shelly Beach. The required staff recruitment and orientation records were sighted in staff records sampled.</p> <p>All previously identified areas requiring improvement have been addressed. A training plan has been implemented with evidence that staff are now receiving, or will be receiving, the required education. The organisation now has an arrangement for ongoing clinical training with a gerontologist nurse specialist commencing in February 2020. The content of this training includes contract agreement topics. Records of individual staff training is now being maintained. Staff performance is monitored in an ongoing manner and annual performance appraisals were sighted in staff records sampled. The registered nurse/clinical manager has completed the interRAI training. There are two staff who have completed the dementia specific training, and all others are now enrolled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	FA	<p>The service has a total of 11 staff including the registered nurse/clinical manager, the deputy lead/facility manager and health care assistants. The registered nurse is on site for up to 20 hours per week.</p> <p>The documented rationale for determining service provider levels and skill mix is based on occupancy ratios. The duty lead/facility manager completes the roster two weeks in advance. The roster was sampled and confirmed there</p>

<p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>are sufficient numbers of staff to cover the 24-hour period. The registered nurse/clinical manager and owner/director are on call 24 hours a day, seven days per week.</p> <p>The previously identified area requiring improvement has been addressed. All staff have a current first aid certificate.</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>FA</p>	<p>There is a safe system for medicine management using an electronic system. The duty leader/facility manager was observed administering lunchtime medicines and demonstrated good knowledge with a clear understanding of the roles and responsibilities related to each stage of medicine management.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse/clinical manager is responsible for medication reconciliation upon readmission from acute care and when medication is received from the pharmacy. The required documentation was sighted on the electronic records sampled. The registered nurse/clinical manager reported that pharmacist input is provided on request and that unwanted medicines are returned to the pharmacy regularly upon delivery of regular medicine packs. A record of returned medicines was sighted.</p> <p>There were no controlled drugs onsite on the day of the audit. The registered nurse/clinical manager and duty leader/facility manager demonstrated knowledge of the appropriate processes to be followed in the management and administration of controlled drugs.</p> <p>The records of temperatures for the medicine fridge and the medication cupboard were within the recommended range. There were no residents who self-administer medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.</p> <p>All previously identified areas of improvement have been addressed. All staff have a current medication competency, the medication trolley is safely stored, there was evidence of three-monthly GP reviews for all prescribed medications and there was no expired stock in the medication cupboard.</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</p>	<p>PA Low</p>	<p>The meals are prepared on site by a qualified cook and a kitchen assistant who covers on the days that the cook is not available. Both the cook and the kitchen assistant have completed safe food handling training.</p> <p>Residents' nutritional requirements are assessed and a diet profile completed on admission. A copy of the diet profile that includes residents' likes and dislikes is provided to the kitchen staff and copies were sighted in the kitchen records sampled. Special diets and modified texture requirements are accommodated in the daily meal plan. Current diet profiles were sighted in residents' records sampled and in the kitchen file. Residents were observed eating special diets and modified textured food on the day of the audit. Supervision and assistance were provided to residents who required it and residents were given adequate time to eat their meals in an unhurried fashion. The</p>

<p>service is a component of service delivery.</p>		<p>registered nurse/clinical manager and healthcare assistants reported that residents have access to food and fluids to meet their nutritional needs at all times with the assistance of the staff. Special equipment is available</p> <p>Monthly residents' weight monitoring was completed and residents with weight loss issues had nutritional supplements provided with dietitian input. Interviewed family and resident reported satisfaction with meals.</p> <p>The previous corrective actions in relation to menu, diet profile reviews, temperatures, food monitoring and addressing resident's weight issues have all been addressed, however an improvement is now required regarding a current food control plan.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Staff were observed providing care to the residents as outlined in the residents' care plans. Individualised care planning was evident in the records reviewed including 24-hour care plans. The GP reported that medical input is sought promptly and medical orders are completed in a timely manner. Care staff confirmed they understood what cares were required from reading the care plans. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> <p>An improvement is required regarding the accuracy and follow up of clinical observations.</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 activities programme is provided by the activities coordinator, a trained diversional therapist, who has completed level four certificate in Diversional Therapy (DT). The duty leader/facility manager and the registered nurse/clinical manager reported that a social history form is completed on admission to identify residents' needs, interests, abilities and social requirements. The DT completes the activities care plans with input from the assessment forms, family/EPOA, care staff and hospital discharge information if applicable. Residents' ability is considered as verified by the staff and family interviewed.</p> <p>The DT completes the activities planner and posts a daily planner on the notice board and a weekly planner. Residents are advised of the activities for the day and are escorted or directed to the activities venue if required. Individual and group activities are offered. The duty leader/facility manager and DT reported that individual activities may be provided to meet the residents' mood at times, for example when restless. Daily activities attendance records were maintained. The DT evaluates the activities care plans six monthly following interRAI reassessments and this was evidenced in the reviewed files.</p> <p>Activities on the planner reflect ordinary patterns of life, specific to needs and abilities of people living with dementia and include normal community activities. Residents were observed participating in a variety of activities on the day of the audit. Interviewed family confirmed their involvement in evaluating and improving the programme through satisfaction surveys.</p>

		24-hour care plans were completed for all residents in reviewed files.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Health care assistants review the residents' care in each shift and document in the progress notes. If any change is noted, it is reported to the duty leader/facility manager and the registered nurse/clinical manager. Six-monthly care plan evaluations were completed following interRAI assessments in the files sampled. Where progress was different from expected, the service responded by initiating changes to the plan of care. Reviewed short term care plans were evaluated as clinically indicated and closed off when conditions resolved. Examples of short-term care plans sampled were for urinary tract infections and wounds. A family member interviewed reported being involved in the evaluation of residents' progress.
<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	There have been no changes to the facility since the last audit. The current building warrant of fitness and approved fire evacuation were sighted. Trail evacuations completed as required.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed for all diagnosed infections.
<p>Standard 2.1.1: Restraint</p>	PA Low	The facility is secure with a key pad exit and a door bell at the entrance. The registered nurse/clinical manager is the restraint coordinator and demonstrated knowledge and understanding of the restraint minimisation processes. The

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>restraint coordinator provides support and oversight for enabler and restraint management in the facility. Restraint minimisation education is part of orientation for all new staff. The use of environmental restraint was included in the restraint policy.</p> <p>The previously identified area of improvement regarding environmental restraint has not been fully addressed. There is evidence that a lot of work has gone into improving staff understanding of environmental restraint, updating policies/procedures and ensuring the resident files contain the required approval to be place. However, on the day of the audit the back door remained locked which continues to prevent residents from independently accessing the secure outdoor area.</p>
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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 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	PA Low	The deputy lead/facility manager has been working at Shelley Beach for 10 years as a health care assistant and has the required dementia training. The registered nurse/clinical manager is on site for 20 hours per week. The registered nurse/clinical manager has access to another registered nurse who works at one of the other facilities. The deputy lead/facility manager's position description has now been amended to include authorities and responsibilities required of a facility manager, however the registered nurse/clinical manager position description does still not include the additional responsibilities and duties of a clinical manager.	The additional authorities and responsibilities for the registered nurse/clinical manager are not defined in the position description.	<p>Define the additional responsibilities and authorities for the registered nurse/clinical manager</p> <p>90 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate</p>	PA Low	A quality and risk management internal audit of the organisation was conducted following the previous audit which looked into strategies, goals and person responsibilities for	Not all risk management strategies	Complete the corrective actions which

<p>communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>monitoring risk associated activities. There is some evidence that organisational risks are now being addressed through the completion of the quality and risk audit, however corrective actions from the audit are yet to be completed.</p>	<p>have been fully implemented.</p>	<p>resulted from the quality and risk management internal audit.</p> <p>90 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>The cook is responsible for managing all aspects of food procurement, preparation, storage, transportation, delivery and disposal. Food, freezer and fridge temperatures, including for high risk items, were monitored appropriately and recorded. The kitchen was clean, no expired food in the pantry and no food items on the floor. All decanted food had expiry dates documented and left-over food was labelled and covered. Cleaning schedules were maintained and records were sighted. The food control plan had recently expired. The organisation is waiting on a letter from their verification agency so they can renew the registration.</p>	<p>There is not a current food control plan.</p>	<p>Renew the food control plan.</p> <p>60 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>Four out of five residents' long-term care plans reviewed had detailed strategies to maintain and promote the resident's independence, wellbeing and, where appropriate, their community involvement. The required nursing admission assessments were completed within 24hours of admission with an initial care plan completed for guidance as required. InterRAI assessments and long-term care plans were completed and evaluations were current. One out of the five files reviewed is for a resident who was admitted within the past three months and the interRAI assessment and long-term</p>	<p>Not all interRAI assessments and long-term care plans were completed within the required time frames.</p>	<p>Complete interRAI assessments within the required timeframes.</p> <p>60 days</p>

		care plan was not yet completed, though the initial care plan was in place with adequate interventions to guide staff for the support required. The registered nurse/clinical manager has recently completed interRAI training and was completing the interRAI assessment for the concerned resident on the day of the audit.		
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Appropriate monitoring and responses were completed following a clinically related adverse event. For example, an unwitnessed fall. Neuro-observations were completed and recorded following an unwitnessed fall however the recorded observations were outside the normal range, with no follow up.	There was insufficient evidence that abnormal clinical observations were noticed or followed up.	<p>Educate all staff regarding normal clinical observations, and how to respond if the observations are outside the normal range.</p> <p>90 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Low	The service has no residents using unapproved restraints or enablers. A door to access the secure garden area was locked, therefore restricting residents' freedom to access the secure gardens around the unit. The registered nurse/clinical manager reported that it was due to a faulty with the door. The issue was reported to the maintenance team.	Residents are still not able to access the all parts of the secure grounds independently.	<p>Provide unrestricted access for residents to the secure grounds.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.