

# Bupa Care Services NZ Limited - St Kilda Care Home

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Bupa Care Services NZ Limited
<b>Premises audited:</b>	St Kilda Care Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 1 October 2018 End date: 2 October 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	68

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

St Kilda Care Home is a Bupa facility. The service provides rest home, hospital and dementia levels of care for up to 80 residents. Occupancy on the day of audit was 68 residents in total.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

The service is managed by a care home manager who has been in the role since July 2017. The care home manager is supported by a clinical manager who has been in the position since August 2017. The management team is supported by the wider Bupa management team, which includes an operations manager. The residents and relatives interviewed spoke positively about the care and support provided.

This audit identified four improvements required around family notification, quality data trends analysis, care planning documentation and implementation of turning charts.

## 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.
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St Kilda Care Home endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrate an understanding of residents' rights and obligations. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are managed and documented and learning's from complaints shared with all staff.

## 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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Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. St Kilda Care Home is implementing the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including quality meetings. Goals are documented for the service with evidence of annual reviews. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Interviews with staff and

review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. There is an in-service training calendar in place. Registered nursing cover is provided 24 hours a day, seven days a week.

## 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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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. A sampling of residents' clinical files included interRAI assessments and care plans for all residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan. Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis. Staff responsible for medication management had current medication competencies. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. There is a large well-equipped kitchen and the kitchen manager/chef oversees provision of the food service. All kitchen staff have completed food safety training.

## 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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The service provider's documentation evidences appropriate (reactive and planned maintenance) systems are in place to ensure the consumers' physical environment and facility is maintained. There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals were stored safely throughout the facility and there is appropriate protective equipment and clothing for staff. Material safety datasheets are available. Housekeeping staff maintain a clean and tidy environment. There is a large well-equipped laundry area with separate clean and dirty areas. There is a system in place to manage soiled linen appropriately and safely. The facility is appropriately heated and ventilated. There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty always.

## 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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There is a Bupa restraint policy that includes restraint procedures including restraint minimisation. There is a documented definition of restraint and enablers that aligns with the definition in the standards. At the time of audit there was one resident with a restraint and no residents using enablers. Staff receive training in restraint minimisation and challenging behaviour management.

## 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.

St Kilda Care Home has an infection control programme that complies with current best practice. The infection control manual outlines a range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. There is a dedicated infection control nurse who has a role description with clearly defined guidelines. The infection control programme is reviewed annually at organisational level. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Education provided includes an evaluation of the session and content delivered. Records of all infections are kept and provided to head office for benchmarking.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	46	0	4	0	0	0
<b>Criteria</b>	0	97	0	4	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with 15 care staff; including eight caregivers, six registered nurses (RN), and one activity coordinator reflected their understanding of the key principles of the Code. Staff receive training about the Code which was last completed in April 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>The service has in place a policy for informed consent and resuscitation. Completed resuscitation treatment plan forms were evident in all nine resident files reviewed. General consent forms were evident in the nine files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Enduring power of attorney (EPOA) evidence is sought prior to admission, and activation documentation is obtained, and both are filed with the admission agreements. Where legal</p>

		processes are ongoing to gain EPOA, this is recorded, as are letters of request to families for the supporting documentation. Residents interviewed confirmed that consent was obtained before undertaking any care or treatment.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy support services is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy support services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings and family meetings are three monthly.
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 on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms.  Complaints forms are in a visible location at the entrance to the facility. Seven complaints made since the last audit (two in 2017 and five in 2018 year to date) were reviewed, with evidence of appropriate follow-up actions taken. Documentation reviewed reflected that complainants were informed of the outcome of the complaint. Feedback is provided to staff and toolbox talks were completed where required.

		As part of a DHB issues-based audit in June 2018 a corrective action plan was developed and implemented around the recording of and responsiveness to family / whanau concerns and queries. The corrective action plan included a comprehensive staff training session on the complaint procedure, toolbox sessions around the recording of and responsiveness of complaints/concerns and discussion on the complaints procedure at the three-monthly resident and family meetings. Evidence of implementation was sighted at this audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, the clinical manager and RNs discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the three-monthly resident and three-monthly family meetings. Six residents (three rest home and three hospital) and twelve relatives (eight rest home, one hospital and three dementia care) interviewed, reported that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training, which was last completed in August 2018.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active

<p>needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>participation and input of the family/whānau in the day-to-day care of the resident. There were no residents whom identify as Māori living at the facility. Māori consultation is available through the local iwi links (Ngati Kahu Hura Tainui). All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. Monthly newsletters are provided to residents and relatives.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Code of conduct training is also provided through the in-service training programme. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff. There are clear ethical and professional standards and boundaries within job descriptions. Registered nursing staff are available 24 hours a day, seven days a week. A main general practitioner (GP) visits the facility two days a week or as needed.</p> <p>The GP reviews residents identified as stable every three months, with</p>

		<p>more frequent visits for those residents whose condition is not deemed stable. Physiotherapy services are provided on-site, eight hours per week. A podiatrist is on-site every six-weeks. The service has links with the local community and encourages residents to remain independent. Residents and relatives interviewed spoke positively about the care and support provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accident/incident forms have a section to indicate if next of kin have been informed of an accident/incident. Fifteen accident/incident forms were reviewed for September 2018. Five of fifteen forms did not have documented evidence that family were informed. Three of twelve relatives interviewed stated that they have not always been informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</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>St Kilda Care Home is part of the Bupa group of aged care facilities. The facility has a total of 80 beds. This includes a 20-bed secure dementia unit, 10 rest home beds and 50 hospital beds. The hospital beds are all dual-purpose. On the day of the audit, there were 68 residents in total, 15 residents in the dementia unit, 28 rest home residents and 25 hospital residents. All residents were under the aged related residential care (ARRC) agreement.</p> <p>A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. St Kilda Care Home is part of the Midlands Bupa region and the managers from this region meet bi-monthly to review and discuss the organisational goals and their progress towards these. The</p>

		<p>2018 St Kilda goals being implemented include, (i) pressure injury prevention, (ii) increasing the activities programme (SMILE programme) and (iii) implementation of the household model of care. Progress to meeting the goals have been reviewed quarterly. The operations manager teleconferences monthly and completes a report to the director of care homes and rehabilitation. A quarterly report is prepared by the care home manager and sent to the Bupa continuous service improvements (CSI) team on the progress and actions that have been taken to achieve the St Kilda Care Home quality goals.</p> <p>The care home manager has been in the role since July 2017 and has over four years' experience in clinical roles with Bupa. She is supported by a clinical manager who has been in the position since August 2017. The operations manager supports the management team and was present at the time of the audit. Staff spoke positively about the support/direction of the current management team.</p> <p>The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p><b>Standard 1.2.2: Service Management</b></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>	<p>FA</p>	<p>The clinical manager who is employed full time, steps in when the care home manager is absent. The operations manager visits regularly and supports both managers.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>A quality and risk management programme is established. Interviews with the managers and staff reflected their understanding of the quality and risk management systems. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented when service shortfalls</p>

		<p>are identified through internal audits and signed off when completed.</p> <p>Riskman has being implemented by Bupa which is an electronic data collecting system. All incidents, complaints, infections, pressure injuries, falls, category one incidents are completed on the online system. The monthly collation of quality data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. However, the quality data trends analysis is not being completed or discussed at quality and staff meetings. Falls prevention strategies are in place and are discussed at the bi-monthly falls focus group meeting. Initiatives in place include intentional rounding, sensor mats, post falls reviews, physiotherapist assessment and recommendation, and individual resident interventions.</p> <p>An annual satisfaction survey is completed and 2018 (September) results demonstrated an 87% overall satisfaction outcome for the resident survey and an 83% overall satisfaction outcome for the relative survey. Corrective actions were established in areas identified around call bell response times, food services and activities.</p> <p>Corrective actions plans were in place from the DHB issued based audit around the call bell response times and the recording of and responsiveness to family / whanau complaints/concerns. Call bell response times is gathered for quality improvement purposes. An audit schedule has been created for call bells as well as an internal audit tool. The service has introduced an awareness campaign on call bells and all staff's responsibilities. Other actions implemented around clinical records include (but not limited to); All RNs have had a 1:1 coaching session with the CM around care planning. Internal audits are being completed around care plans. Family's involvements in documented care planning are included on the family/ whanau record. External wound management training has been undertaken by the wound nurse champion. Relevant learnings have been shared with staff.</p> <p>The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. There is a health and safety officer (maintenance officer) who is supported by health and safety representatives. The health and safety committee team meet three monthly. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this</p>
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		has been completed. The hazard register is reviewed regularly
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. All incidents are coded in severity on Riskman (severity 1-4) with 4 being the most severe. All resident incidents logged with a severity of 3 or 4 are automatically escalated to the Bupa CSI team immediately and the operations manager. Actions are then followed up and managed. Fifteen accident/incident forms were reviewed across the three service areas (link 1.1.9). Each event involving a resident, reflected a clinical assessment and follow-up by a RN. Incidents are analysed for trends. Neurological observation forms were documented and completed for four unwitnessed falls with a potential head injury.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There have been five section 31 notifications made since the last audit. Four unstageable pressure injuries in August, November and December 2017 and March 2018, and one power outage in June 2018.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></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 resources policies in place, including recruitment, selection, orientation and staff training and development. Nine staff files (one care home manager, one clinical manager, two RNs, three caregivers, one maintenance officer and one activities coordinator) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies.</p> <p>The caregivers, when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. There is an annual education and training schedule in place for 2018. The service provides regular in-service education and sessions have been provided</p>



		<p>that address all required areas. Of the eleven RNs at St Kilda Care Home, five have completed interRAI training. Eighty three percent of the total staff have attained at least one Bupa Personal Best certificate. A total of 54% of caregivers have attained a national certificate qualification. There are ten caregivers that work in the dementia unit and nine have completed the required dementia standards. One caregiver is in process of completing their dementia standards and has commenced work within the last 18 months.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a care home manager and clinical manager who both work full time from Monday to Friday. The care home manager and clinical manager share the on-call duties. Registered nurse cover is provided 24 hours a day, seven days a week. Separate laundry and cleaning staff are employed seven days a week. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p> <p>The hospital/rest home beds are split into three units. Carbine unit has 22 of 25 residents (17 rest home and five hospital) and Tavistock/Tristram unit has 31 of 35 residents (23 rest home and eight hospital). There are two RNs on duty on the morning, afternoon and night shifts (one in Carbine and one in Tavistock/Tristram). The RNs are supported by adequate numbers of caregivers. In Carbine there are four caregivers on duty on the morning shift, three on the afternoon shift and one caregiver on the night shift. In Tavistock there are four caregivers on duty on the morning shift, three on the afternoon shift and one caregiver on the night shift.</p> <p>There are 15 of 20 residents in the Lamond dementia unit. Lamond has one RN on duty in the morning shift. There are three caregivers on duty on the morning shift, two on the afternoon shift and one caregiver on the night shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours</p>

recorded, current, confidential, and accessible when required.		of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure, in separate locked and secure areas.
<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>	FA	<p>Admission policies and processes are documented. Prior to entry all potential residents have a needs assessment completed by the needs assessment and coordination service to assess suitability for entry to the service. Residents receive an information pack outlining the services able to be provided, the admission process and entry to the service. Residents and relatives interviewed, confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the care home manager or clinical manager. Signed admission agreements were sighted in all nine resident files reviewed (three from each of the hospital, rest home and dementia units).</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>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur.</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>	FA	<p>The service has a robust medication management system, policies and procedures in place. Regular internal audits are undertaken to ensure compliance. Prescribed medications are delivered to the facility and checked on entry by the RN. Medications were appropriately stored with medicines stored in original dispensed packs. The controlled drug register documented weekly checks and six-monthly physical stocktakes. The fridge temperatures are conducted and recorded daily. All staff (RNs and senior caregivers) authorised to administer medicines have current competencies.</p> <p>There is an electronic medication management system in place for most</p>

		<p>residents. On the day of audit, three residents had a paper-based file due to a different GP. These charts and signing charts were up to date and correct. All staff administering medications had completed training for the electronic system. Medication rounds were observed and evidenced good practice according to policy. Administration records are maintained, as are staff specimen signatures. There was evidence of compliance around medication prescribing. There were no residents who self-administer medications.</p>
<p>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.</p>	<p>FA</p>	<p>All food and baking are prepared and cooked on-site. The kitchen manager/cook is supported by a chef and three kitchenhands. Staff have been trained in food safety and chemical safety. There is an organisational four weekly seasonal menu that had been designed in consultation with the dietitian at an organisational level. Meals are delivered via bain maries to each of the four wings. The chef serves the food in the hospital wing. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated.</p> <p>Special diets such gluten free, dairy free, diabetic desserts and pureed/soft diets are provided. Nutritious snacks are available 24 hours in the dementia unit. Freezer and chiller temperatures and end-cooked temperatures are taken and recorded daily. Corrective actions are in place and sighted for any issues. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date-labelled. A cleaning schedule is maintained. Kitchen staff were observed to be wearing appropriate personal protective clothing. Residents can provide feedback on the meals through resident meetings, survey and direct contact with the chef or cook.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the</p>	<p>FA</p>	<p>The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred to the needs assessment service or</p>

organisation, where appropriate.		referring agency for appropriate placement and advice.
<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 facility has embedded the interRAI assessment protocols within its current documentation. Risk assessments and care plans were completed and were detailed for all the resident files reviewed. InterRAI initial assessments and assessment summaries were evident in printed format in all long-term resident files. All nine resident files reviewed identified that the Bupa risk assessment book had been completed on admission and ongoing interRAI based assessments completed six-monthly as part of the evaluation. Additional assessments for management of behaviour, pain and wound care were appropriately completed according to need.
<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	All resident care plans sampled were resident centred. However, interventions to support all assessed needs were not always documented in detail in the care plans. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations and they are involved in the care planning and review process. The interRAI assessment process informs the development of the resident's care plan. Short-term care plans are in use for changes in health status. Short-term care plans are signed off once completed or transferred to the long-term care plan. Caregivers interviewed reported they access the resident file to review care plans and write progress notes. Specific care plan templates were implemented for specific health needs, including (but not limited to) dementia care, medical needs, diabetes, pressure injury management and prevention and wounds.
<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>	PA Low	Registered nurses and caregivers follow the care plan in the resident file and report progress against the care plan at handovers. If external nursing or allied health advice is required, the RNs will initiate a referral (district nurse, hospice nurse, mental health or other specialist nurses). If external medical advice is required, this will be actioned by the GP. Caregivers and RNs interviewed stated there is adequate equipment provided, including continence and wound care supplies. Sufficient

		<p>continence products are available and resident files include a continence assessment and plan as part of the plan of care.</p> <p>Wound care plans, behaviour plans, pain management and specific resident plans (bowel management) were sighted. Not all repositioning charts had been documented as per plan. Wound management plans were fully documented for all current wounds. Wound re-assessment and rationale for when changes were made to the wound plan were fully documented with each dressing change. There were 27 wounds present on the day of audit; this included minor wounds such as scratches and previous wounds now healed, that were for observation. There were also two pressure injuries on the day of audit. All wounds have been assessed and evaluated in required timeframes. The RNs have access to specialist nursing wound care management advice through the district health board (DHB) wound care nurse specialist if required. Interviews with RNs and caregivers demonstrated an understanding of the individualised needs of residents.</p> <p>It was noted that call bells were within reach and sensor mats appropriately placed and switched on. Residents were observed to be well dressed including shaves as needed.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A fulltime diversional therapist (DT) oversees the activities programme provided across seven days per week. There are three programmes with a range of activities offered. There are separate programmes with activities that meet the needs and preferences of the three resident groups, however many activities are integrated such as entertainment, as observed on the day of audit. Variations to the group programme are made known to the residents. Residents may choose to participate in any group programme. Individual programmes are delivered to residents in their rooms when they are unable to or choose not to participate in the group programme. There is a specific programme for the dementia residents. The group programme covers physical, cognitive, social and spiritual needs.</p> <p>There are regular visiting entertainers and community groups. Activities provided are meaningful and include (but are not limited to): newspaper reading, current affairs, reminiscing, crafts and quizzes. There are weekly van outings into the community areas of interest for residents (eg, Avanti Drone where residents ride trikes). There is a 'music moves' (sit</p>

		<p>dance exercise) class that has now become part of the monthly programme. Community people visit and provide (but not limited to); pencil art sessions, piano sessions and pet therapy. There are pets residing in the home. There is a 'sensory room' with (but not limited to) a lazy boy chair, sensory lighting, aromatherapy and music. The DT interviewed stated that residents with behavioural challenges settle quickly once utilising the sensory room.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans were evaluated by the RN within three weeks of admission. Care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The GP reviews residents at least three-monthly or when there is a change in health status. The family members interviewed confirmed they are invited to attend the GP visits and multidisciplinary care plan reviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Discussions with RNs identified that the facility has direct access to services including DHB nurse specialists, podiatrist and physiotherapy (contracted) services.</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>There are policies in place to guide staff in waste management. All staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled</p>

		correctly and were stored safely throughout the facility. Safety datasheets are available.
<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 certificate for public use dated 21 December 2018. Reactive maintenance and a 52-week planned maintenance schedule in place has been maintained. There is a full-time maintenance person employed. Medical equipment has been calibrated on purchase. The hot water temperatures are monitored weekly and are maintained between 43–45 degrees Celsius. There are contractors for essential service available 24/7. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas and garden landscaping has been completed and are well maintained. There is outdoor furniture and seating and shaded areas. There is wheelchair access to all areas. The caregivers and RNs interviewed stated they have all the equipment referred to in care plans necessary to provide care. The dementia unit has two lounge areas designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas and seating alcoves that provide privacy when required. There is a safe and secure outside walking and garden area, which is easy for dementia residents to access.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All bedrooms in the rest home and hospital have access to ensuites. There are adequate numbers of communal toilets located near the communal areas. There is appropriate signage, easy-clean flooring and fixtures, and handrails appropriately placed. Residents interviewed reported their privacy is always maintained. Residents in the dementia unit share an ensuite, with automatic locks to protect the resident's privacy. There is an emergency release button for staff to use if required.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas</p>	FA	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids.</p>

appropriate to the consumer group and setting.		Residents are encouraged to personalise their bedrooms.
<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	All bedrooms are single. The rest home and hospital bedrooms are spacious enough to manoeuvre transferring and mobility equipment to deliver care safely and easily. The bedroom doors are wide enough to allow ambulance access if required. The dementia care unit bedrooms are spacious. Residents are encouraged to personalise their bedrooms as desired.
<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 cleaning policies and processes. The cleaners' cupboards are designated areas and are lockable for storage of chemicals. All chemicals are labelled and stored securely. Cleaning and laundry audits occur as per the internal audit system. The laundry and cleaning rooms are designated areas and clearly labelled. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. Residents interviewed were satisfied with the standard of cleanliness in the facility and with the current laundry services.
<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	An emergency/disaster management plan is in place to guide staff in managing emergencies and disasters. The emergency plan was put into practice with a power outage in June 2018. A corrective action plan was developed and implemented for any improvements required around the power outage process. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member with a current first aid certificate is on duty at all times. There is an approved fire evacuation plan dated 16 December 2014. Fire evacuation drills take place every six months, with the last fire drill occurring on 23 August 2018. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities (two BBQs) for cooking in the event of a power failure. There is a battery backup system in place for emergency lighting. Civil defence supplies are available and are checked annually. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets, torches and batteries are available. There is sufficient water stored (ceiling water tanks and bottled water) to



		<p>ensure for three litres per day per resident for three days.</p> <p>Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. An unannounced DHB audit in June 2018 evidenced that not all call bells were being answered within a three-minute period. An internal audit in July 2018 identified that 23.6% of call bell responses in the Tavistock/Tristram unit were being answered over a three-minute period. Corrective actions were developed and implemented with daily monitoring and reports being completed and analysed. At the time of the audit, analysis was completed for the Tavistock/Tristram unit and identified that call bell responses have reduced to 6.58% over a three-minute period. Corrective actions are continuing for the Tavistock/Tristram, Carbine and Lamond units around the call bell response time reductions. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. Access by the public is limited to the main entrance. The dementia unit has a secure entrance.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. The facility has central heating that is thermostatically controlled. All bedrooms and communal areas have at least one external window.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>St Kilda Care Home follows the Bupa infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Bupa KPIs. The clinical manager is the designated infection control nurse and has access to the DHB infection control nurse and microbiologist. Audits have been conducted and include hand hygiene, infection control practices in the laundry and cleaning service. Education is provided for all new staff on orientation. Staff interviewed stated they had adequate supplies of personal protective equipment (PPE). The infection control programme is reviewed annually by the corporate quality and risk team.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical manager is the infection control nurse and is aware of the need to analyse data and the reasons behind this. The infection control nurse receives ongoing education and attends the Bupa IC conference annually. In the event of the infection control nurse requiring advice this is available through the GP, the DHB resource person or Bug Control.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection control policies link to other documentation and uses references where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control nurse ensures training is provided to staff. Informal education is provided, availability of the education was confirmed by caregivers interviewed. The orientation package includes specific training around hand washing and standard precautions. Hand washing is an annual competency. Resident education is expected to occur as part of providing daily cares.</p>
<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	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs and laboratory that advise and provide feedback/information to the service.</p> <p>Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control nurse. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking.</p>

		Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. At the time of the audit, the service had one resident using a restraint (bed rails) and no residents using any enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours.
Standard 2.2.1: Restraint approval and processes 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.	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Ongoing consultation with the resident and family/whānau are evident. The file for the resident using restraint was reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies

		to try (as appropriate) before restraint is used. The care plan reviewed for the resident with a restraint, identified observations and monitoring. Restraint use is reviewed through the three-monthly assessment evaluation, monthly restraint meetings and six-monthly multidisciplinary meeting which includes family/whānau input. A restraint register is in place, providing a record of restraint use and is completed for residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred three-monthly as part of the ongoing reassessment for the residents on the restraint register and as part of their care plan review. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed three monthly through the monthly restraint meeting and as part of the internal audit programme. Review of this use across the group is discussed at the regional restraint approval group teleconference meeting and information is disseminated throughout the organisation.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Fifteen accident/incident forms were reviewed for September 2018. Five of fifteen forms did not have documented evidence that family were informed. Three of twelve relatives interviewed stated that they had not always been informed when their family member's health status changes.</p>	<p>Accident/incident forms have a section to indicate if next of kin have been informed of an accident/incident. Fifteen accident/incident forms were reviewed for September 2018. Five of fifteen forms did not have documented evidence that family were informed. Three of twelve relatives interviewed stated that they are not always informed when their family member's health status changes.</p>	<p>Ensure that all next of kin are informed of any accident/incident and changes in health status to their family member.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated</p>	PA Low	<p>Riskman has been implemented by Bupa, which is an electronic data collecting system. At St Kilda, all incidents, complaints, infections, pressure injuries,</p>	<p>The monthly collation of quality data is available; however, the quality data trends analysis is not documented as being completed. Quality and staff meetings</p>	<p>Ensure that quality data trends analysis is completed monthly and is discussed at quality</p>

and the results communicated to service providers and, where appropriate, consumers.		falls, category one incidents are completed on the online system. The monthly collation of quality data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors, however the quality data trends analysis is not being documented as completed or discussed at quality and staff meetings.	reviewed did not evidence discussion of quality data analysis and trends.	and staff meetings.  90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	All nine residents had care plans in place and care plans were individualised. Care staff interviewed were able to describe the care and support for all residents and demonstrated in-depth knowledge of their care needs. However, interventions to support all assessed needs were not always documented in detail in the care plans.	Care plans did not include all interventions to safely guide care and support;  (1).Two of three dementia care plans did not include interventions to support all assessed needs; (i) one resident did not have interventions to manage refusal of care. (ii) one resident did not have the care and support needed for a leg calliper.  (2). Two of three rest home care plans did not include interventions to support all assessed needs; (i) one resident who smoked did not have interventions documented to support the risks; (ii) one resident did not include interventions to support wandering and 'getting lost' in the facility.  (3) One of three hospital care plans did not include interventions to support all assessed needs. (i) one resident did not have interventions comprehensively documented around how the resident communicates pain.	Ensure that care plans reflect care interventions to support current assessed needs.  60 days
Criterion 1.3.6.1	PA Low	Families and residents all commented	Three residents with repositioning charts	Ensure that

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>favourably of the care and support provided to residents. All residents had an individualised plan including a 'My day my way' 24-hour care plan based on the resident's previous schedule and desires. Staff were aware of resident needs and observation of staff demonstrated a caring approach to all residents. Repositioning charts were not always documented according to timeframes.</p>	<p>did not have all interventions documented two hourly as per care plan (one rest home and two hospital).</p>	<p>repositioning charts are documented as per care plan.</p> <p>60 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.