

# Presbyterian Support Central - Coombrae

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Presbyterian Support Central

**Premises audited:** Coombrae Elderly Care

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 3 August 2015 End date: 3 August 2015

**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:** 41

# 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

Coombrae Home is owned and operated by the Presbyterian Support Central and cares for up to 44 residents requiring rest home and rest home (dementia) level care. On the day of the audit there were 41 residents. The manager is well qualified and experienced for the role. Residents, relatives and the general practitioner (GP) interviewed, spoke positively about the service provided.

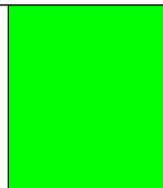
This surveillance audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with relatives, staff and management.

Five of the seven shortfalls identified at the previous audit have been addressed. These are around open disclosure, complaints management, internal audits, care planning and storage of chemicals. Improvement continues to be required around assessments and aspects of medication management.

This audit has identified improvements are required around corrective action planning; dementia related training for staff, timeliness of evaluations care interventions and registered nurse medication competencies.

## 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.

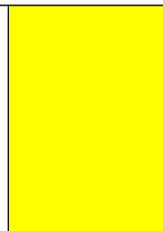


Standards applicable to this service fully attained.

The service ensures effective communication with all stakeholders including residents and families. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of low risk.

Coombrae Home has a quality and risk management system in place. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with evidence of benchmarking outcomes with other similar aged care facilities. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are stored in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness. All chemicals sighted were stored safely.

## 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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Coombrae Home continues to provide a restraint free environment. There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. There is one resident using an enabler. Enabler use is voluntary.

## 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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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	13	0	3	3	0	0
<b>Criteria</b>	0	35	0	4	3	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and procedures has been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the service. Staff interviewed (three healthcare assistants and the clinical care manager) were aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Two complaints were received in 2014 and two in 2015 to date. Systems and processes have been implemented and documentation reviewed confirms that all complaints received were managed and resolved appropriately. This is an improvement since the previous audit. Family members and residents interviewed advised that they are aware of the complaints procedure and how to access forms.</p> <p>There is written information on the service philosophy and practices particular to the dementia unit included in the information pack.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Two family members (from the dementia unit) interviewed, stated they are informed of changes in health status and incidents/accidents. This is confirmed on the 10 incident forms sampled and this is an improvement since the previous audit. Family members and residents (six from the rest home) also stated they were welcomed on entry and were given time and explanation about services and procedures. The manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for</p>

consumers and provide an environment conducive to effective communication.		residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available.
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Coombrae Home is owned and operated by Presbyterian Support Central. The service provides care for up to 44 residents requiring rest home and secure dementia level care. On the day of the audit, there were 31 residents at rest home level care and 10 in the secure dementia unit. The manager is a non-practicing registered nurse who has been in management for 15 years and in this role for two and a half years. She is supported by a clinical care manager who is a registered nurse and has had this role for four and a half years. The current business plan has been implemented including a number of actions with timeframes for Coombrae Home. The manager has completed more than eight hours of professional development related to the management of a rest home in the past year.
Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	The organisation wide risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the staff meeting. All quality data is electronically logged and monitored by the manager and clinical care manager. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Discussions with staff confirmed their involvement in the quality programme. Data is collected on complaints, accidents, incidents, infection control and restraint use (which is nil). The internal audit schedule for 2014 has been completed and is underway for 2015. All audits are signed and dated when completed. These are improvements since the previous audit. Areas of non-compliance identified at audits have been developed but not always signed as completed. Benchmarking with other facilities occurs on data collected. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies and procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. There is a death/Tangihanga policy and procedure that outlines immediate action to be taken upon a resident's death. Falls prevention strategies are implemented for individual residents. Residents and relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to staff and families.
Standard 1.2.4: Adverse Event	FA	Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of

<p>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>		<p>resident related incident reports for July 2015 were reviewed. All reports and corresponding resident files reviewed, evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data with other facilities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 10 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. The orientation programme is relevant to the dementia unit and includes a session on how to implement activities and therapies.</p> <p>Annual appraisals are conducted for all staff. A completed in-service calendar for 2014 exceeded eight hours annually and the 2015 in-service programme is being completed. The clinical care manager and registered nurses are provided with on-going training relevant to the roles within the wider group.</p> <p>There are 10 caregivers who work in the dementia unit. Six have completed the required dementia standards. Three who have not yet worked at the service for 12 months are enrolled in the course and the one not yet enrolled is a new employee. One of the two activities staff who works in the dementia unit has not completed dementia related training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	<p>FA</p>	<p>Coombrae Home has a weekly roster in place, which provides sufficient staffing cover for the provision of care and service to residents. The clinical care manager (a registered nurse) works full time Monday to Friday and is supported by two other registered nurses who work 16 and 24 hours per week respectively, including covering the weekends. There is registered staff available on site or on call 24 hours per day. Healthcare assistants, residents and family interviewed advised that sufficient staff are rostered on for each shift. There is a staff member on duty that has been trained in first aid and CPR at all times.</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The service uses individualised blister packs, which are checked in on delivery by the clinical care manager. This is an improvement since the previous audit. The clinical care manager was observed administering medications correctly. Medications and associated documentation were stored safely and securely. All medication checks were completed and met requirements, with the exception of eye drops. This was a previous shortfall that continues to require improvement. Seven of 10 medication charts evidenced three monthly medical reviews by the attending GP. This previous shortfall continues to require addressing. Resident photographs were evident in the sample of medication charts reviewed and all as required medications had a documented indication for use. This is an improvement since the previous audit. An annual medication administration competency is completed for all health care assistants who administer medications and medication training had been conducted.</p> <p>Policy and procedures are in place for residents who wish to self-medicate. There was one resident who self-administered medications. A current competency assessment was evidenced. Individually prescribed resident medication charts are in use and this provides a record of medication administration information.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at the service are prepared in a well-appointed kitchen and cooked on site by the cook. There is a five weekly winter and summer menu, which has been reviewed by a dietitian. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. The service records all fridge and freezer temperatures daily. Staff were observed serving and assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses. Six monthly nutritional assessments are completed for all residents and more frequently if required. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and</p>	<p>PA Moderate</p>	<p>The previous audit identified that not all pain assessments were completed. This continues to require improvement. All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate as sighted in files sampled. The clinical care manager and one RN have received training in interRAI and continue to transition residents at Coombrae on to InterRAI. Not all the required assessment tools were completed or reviewed at least six monthly, in the files sampled. Care plans reviewed were</p>

preferences are gathered and recorded in a timely manner.		developed on the basis of these assessments for files sampled.
Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The previous audit identified that short term care plans were not used for all short term needs. Care plans did not include all required interventions and there was no evidence of family and resident input into care planning.  The five files sampled for this audit demonstrated that short term care plans were used for all short term needs. Care plans were comprehensive and included interventions for all assessed needs and desired outcomes and that family and/or the resident have input into the development of the care plan. The previous shortfalls have been addressed.
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Care plans sampled were current and interventions reflect the assessments conducted and the identified requirements of the residents. Interviews with staff and relatives confirmed involvement of families in the care planning process. Dressing supplies are available and a treatment room was stocked for use. Contenance products are available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. There was one resident with a wound, which had not been reviewed in current timeframes. There are currently no residents with pressure areas. One resident file sampled had a fluid balance chart which had not been consistently documented.
Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities staff provide an activities programme over seven days each week, based on the Eden philosophy. The programme is planned monthly and a copy is placed on the notice board. An activity plan is developed for each individual resident based on assessed needs as part of the care plan. Monthly progress notes are recorded. The activity plan is reviewed six monthly along with the residents nursing care plan. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service uses a van for resident outings. Residents were observed participating in activities on the day of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans in the sample of files reviewed, were noted to have been updated as care requirements changed. Full care plan evaluations were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions in the sample of files reviewed. Short term care plans have been utilised and any changes to the long term care plan were dated and signed in the files sampled. Four of five care plans reviewed were not evaluated within the required time frames (link 1.3.3.3).</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>	<p>FA</p>	<p>The previous audit identified that one unlocked kitchen cupboard in the dementia care unit contained a bottle of Ecolab heavy duty degreaser. During a tour of the facility, it was noted that all chemicals were stored securely and had manufacturer's labels. The service has addressed this previous finding.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current building warrant of fitness, which expires on 8 July 2016.</p>
<p>Standard 3.5: Surveillance</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. The clinical care manager is the designated infection control nurse. Monthly infection</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>		<p>data is collected for all infections based on signs and symptoms of infection. All infections are individually logged on the electronic database. The data has been monitored and evaluated monthly and annually and is benchmarked by an external provider.</p>
<p>Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Coombrae Home continues to provide a restraint free environment. There was one resident using an enabler. Enabler use is voluntary. Staff are trained in the management of behaviours that challenge.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	When service shortfalls are identified through internal audits, a corrective action plan is developed that includes timeframes and responsibilities. These have not consistently been signed off as completed. Staff interviewed confirmed corrective actions are addressed.	Corrective action plans are not consistently signed off as completed.	<p>Ensure that corrective action plans are checked and signed off when completed.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	One of the two activities staff (both of who work in the dementia unit) has almost completed the diversional therapy training. Caregivers are required to complete the required dementia standards within 12 months of commencing employment and this is being achieved.	One of the two activities staff who works in the dementia unit has not completed dementia related training.	<p>Ensure all staff who work in the dementia unit complete dementia related training.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Medication is stored appropriately in locked medication rooms. All residents have medication charts. Gaps around documentation have been identified in the sample of medication charts reviewed. Staff administering medication were observed to sign for medication after it was administered. Dating of eye drops on opening has inconsistently been completed.</p>	<p>The 10 medication files sampled showed: i) one of 10 files documented that the resident's medication was not administered in line with the prescribed medication order; ii) three out of 10 files have not been consistently reviewed three monthly by the GP; iii) two out of 10 files do not have allergy or nil allergy documented; and iv) two eye drops in the dementia unit have not been dated on opening.</p>	<p>i) Ensure medications are administered as prescribed; ii) ensure medication reviews are conducted at least three monthly by the GP; iii) ensure that all resident's medication charts have allergies or nil allergies documented; and iv) ensure that eye drops are dated when opened.</p> <p>60 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Low</p>	<p>All health care assistants who administer medication have had their competency reviewed annually and registered nurses three yearly. Medication education had occurred for all staff that administer medication.</p>	<p>Three of three RN's have not completed annual medication competencies.</p>	<p>Ensure all RN's complete medication competencies annually.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>The registered nurse completes an initial care plan on admission and the initial assessments. The families are involved in the care planning process. Medical assessments and three monthly medical reviews were documented in all five files by a general practitioner (GP). More frequent medical assessment/review was noted as occurring in residents with acute conditions. Care plan evaluations were conducted in a timely manner in one of five resident files reviewed.</p>	<p>Four of five care plans sampled have not consistently had evaluations completed six monthly.</p>	<p>Ensure that all care plans are reviewed at least six monthly.</p> <p>90 days</p>

<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Moderate</p>	<p>Three of five files reviewed had assessments completed for identified care issues including (but not limited to) nutrition, falls risk, pressure risk and manual handling and pain. These have been reviewed at least six monthly.</p>	<p>There are no pain intervention evaluation flow charts in place to monitor the effectiveness of pain relief. One resident had not had a pain assessment conducted following the discontinuation of narcotic pain relief; and one resident with pain identified on admission, had no pain assessment completed.</p>	<p>Ensure that pain assessments are completed and reviewed for identified pain.</p> <p>60 days</p>
<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>	<p>PA Moderate</p>	<p>Wound assessment and wound management plans were in place for one resident. Documentation reviewed did not reflect evaluation within identified timeframes. There were identified links documented between short term care wound management and long term care plans. Monitoring charts are completed when required. Documentation gaps were identified in a fluid balance chart sighted.</p>	<p>i) The fluid balance chart for one resident file sampled had not been fully completed; and ii) the one current wound had not consistently been reviewed within the stated timeframe.</p>	<p>i) Ensure that all monitoring charts are fully completed; and ii) ensure that all wounds are reviewed as per stated timeframes.</p> <p>60 days</p>

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

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

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

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

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End of the report.