

Karaka Court Limited - Woodlands of Palmerston North

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:	Karaka Court Limited	
Premises audited:	Woodlands Of Palmerston North	
Services audited:	Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 17 February 2017	End date: 17 February 2017
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:	28	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
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

Woodlands of Palmerston North is owned by Karaka Court Limited who operate two homes in the Manawatu. Woodlands of Palmerston North provides care for up to 38 residents across two service levels (rest home and dementia). On the day of audit there were 28 residents. Woodlands is managed by an experienced manager, who is also supported by a clinical leader with access to additional clinical support from the Feilding facility. The residents and relatives interviewed spoke positively about the care and support 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 the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

All six findings identified at the previous audit including admission agreements, professional development for the manager, management of policies and procedures, medication management, the activities programme and the call bell system have been addressed.

This audit identified improvements required around the staff performance appraisals, training, InterRAI assessments, service delivery interventions, documentation of registered nurse input in care, food services and controlled drug administration.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Full information is provided to residents and family/whānau and open disclosure is practiced. Resident admission agreements are signed appropriately. The rights of the residents and/or their family to make a complaint is understood, respected and upheld by the service. 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 medium or high risk and/or unattained and of low risk.
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Services are planned, coordinated and are appropriate to the needs of the residents. There is a 2016/2017 business plan for the service that outlines objectives for the year. The manager and clinical leader/registered nurse (RN) are responsible for the day-to-day operations. A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes. There are human resources policies to support recruitment practices. An orientation programme is in place for new staff. There is an annual education/training schedule in place. There are at least two care staff on every shift. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Admission procedures, assessments and care plans are carried out by the RN. A range of assessment tools were completed along with InterRAI assessments

Activities programmes are run by the diversional therapist, who has been with the service for 15 years. Daily prompts of activities occur and residents from the dementia unit participate in rest home activities as appropriate. Community connections are maintained.

Care plan evaluations were completed at least six monthly and residents and family are involved in reviewing care.

There are policies and procedures to ensure safe medication management implementation. The registered nurse and medicine competent caregivers administer medicines. Medicine competencies are reviewed annually. Medication reviews were completed by the GP at least three monthly. The service has four-weekly rotating summer and winter menus. Food is prepared and cooked on site.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

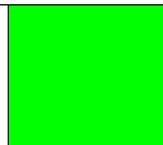


Standards applicable to this service fully attained.

The building holds a current warrant of fitness which expires in 4 April 2017. Call bells are in working order.

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.

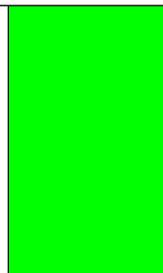


Standards applicable to this service fully attained.

There are policies around restraints and enablers including definitions. On the day of the audit there were no residents using a restraint or an enabler.

Infection prevention and control

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



Standards applicable to this service fully attained.

Infection control surveillance occurs and it is appropriate for the size and complexity of the service.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	2	3	0	0
Criteria	0	36	0	2	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: 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>Five resident files sampled demonstrated the consents were signed by the resident (if competent) or their EPOA. Informed consent and resuscitation orders were appropriately recorded in all files reviewed. Written consents are signed by the resident or their enduring power of attorney (EPOA). Advanced directives are signed for separately. Families interviewed confirmed that information was provided to enable informed choices to be made for their family member.</p> <p>Five admission agreements reviewed were all signed on the day of admission or within a week of entry to the service. Admission agreements were provided to the residents and their EPOA or family members on the day of admission. Resident and family and management interviews confirmed this. The required corrective action from the previous audit has been addressed.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. A record of all complaints, both verbal and written is maintained by the manager using a complaint's register. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Code of Rights. There have been no complaints received since the last audit. Care staff interviewed confirmed that complaints and any required follow-up is discussed at staff meetings. Residents and family members advised that they are aware of the complaints procedure and how to</p>

understood, respected, and upheld.		access forms.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Full information is provided at entry to residents and family/whānau. The information pack is available in large print and can be read to residents who are visually impaired. Nine residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. The manager and clinical leader/RN are both available to residents and families and they promote an open-door policy. Family are informed of an accident/incident unless the resident has consented otherwise. This was confirmed in the sample of twelve accident/incident forms reviewed. Interview with the clinical leader/RN confirmed family are notified following changes in health status. Family (two rest home) advised that they are notified of incidents and when residents' health status changes. Residents' meetings every two months provide a forum for residents to discuss issues or concerns on every aspect of the service. Interpreter services are available.</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>Woodlands of Palmerston North provides care for up to 38 residents across two service levels (rest home and dementia). On the day of audit there were 18 rest home residents and 10 residents in the dementia unit. There were three boarders living independently at the facility. There was one rest home resident on a younger person with disability contract (YPD) and another on respite care at the time of the audit. All other residents were under the ARC contract.</p> <p>The two company directors of Karaka Court Ltd operate two facilities, Woodlands of Palmerston North and Feilding. There is a 2016/2017 business plan that covers both the Woodlands of Palmerston North and Feilding facilities and outlines objectives for the year. Woodlands of Palmerston North and Feilding share operational accounts (administration costs) for both homes. All transactions of income and expenditure are in relation to the individual home.</p> <p>The service is managed by an experienced manager (non-clinical) who has been in the post for nine years. She reports to one of the directors monthly and is supported by a clinical leader/RN who works full time Monday to Friday. The clinical leader/RN has been in her role for two years. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home (sighted). The previous finding has been addressed around annual professional development training for the manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	FA	<p>A quality and risk management plan May 2016 to May 2017 is in place with goals listed. Policies and procedures have been developed with assistance provided by an external quality consultant. Policies were last reviewed in August 2016. The quality consultant is currently progressing with a complete review of all policies/procedures to include best practise and recent changes (eg, health and safety legislation). The previous finding has been addressed around the review management and updating of policies. Policies are now linked to InterRAI. Staff are</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>made aware of any policy changes through regular meetings and by reading (and signing) information that is held in a reading file in the staff room.</p> <p>The monthly collating of quality and risk data includes monitoring accidents and incidents and infection rates. Internal audits monitor compliance. Areas identified for improvement are documented on an audit summary sheet. Quality improvement plans are raised for corrective actions and areas for improvement. These have been followed up, signed off when implemented and outcomes are reported in the monthly meetings. Meeting minutes are posted in the staff room. Staff who are unable to attend meetings are asked to sign that they have read the meeting minutes.</p> <p>Annual resident/relative and food satisfaction surveys have been completed and collated with results provided to staff and residents. The last resident/relative survey was completed in August 2016 and food satisfaction survey in September 2016. Results reflect that the residents are satisfied or very satisfied with the overall services received. Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Sensor mats are available if needed and falls risk assessments are in place. A physiotherapist is available on an as needed basis.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective actions to minimise, and debriefing. Twelve incident reports selected for review reflect immediate action(s) taken and document follow-up action(s) taken by the clinical leader/RN (link 1.3.6.1).</p> <p>The service collects monthly data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. Monthly quality/staff meeting minutes evidenced discussions of incidents and accidents. This information is posted in the staff room. Discussions with the management team confirmed their awareness of statutory requirements in relation to essential notification.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>PA Moderate</p>	<p>There are human resources policies to support recruitment practices. Six staff files were reviewed (one manager, one clinical leader/RN, one cook, two caregivers and one cleaner) and all had relevant documentation relating to employment. Annual performance appraisals are reviewed annually as stated in the recruitment policy. Annual performance appraisals have not been completed for the manager and the clinical leader/RN within the last 12 months. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>(sighted in files of newly appointed staff). Staff interviewed could describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an annual education/training schedule in place. Not all mandatory training topics have been covered in the last two years. Medication competencies are completed annually for caregivers and the clinical leader/RN. The clinical leader/RN has completed InterRAI training. There is a staff member with a current first aid certificate on every shift. There are 15 caregivers who work in the dementia unit; 14 have completed 'gerontology level 7' as part of the RN competency training programme, which includes dementia care. The caregiver who has not completed the required dementia standards has commenced work within the past six months. The activities coordinator is a trained diversional therapist.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. A full time clinical leader/RN and the manager (non-clinical) are on site Monday to Friday. The clinical leader/RN is on-call 24/7 when not on-site. There are at least two care staff on every shift. Care-giving staff are responsible for laundry. Cleaning staff work five days a week, four hours a day. A diversional therapist provides activities on a full-time basis Monday to Friday. Staff reported that staffing levels and the skill mix was appropriate and safe. Residents and family interviewed advised that they felt there is sufficient staffing.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures to ensure safe medication management implementation. The registered nurse and medicine competent caregivers administer medicines. Medicine competencies are reviewed yearly. Medication reviews are completed by the GP at least three monthly.</p> <p>Medication charts have photo identification and allergies and sensitivities are documented. Residents' allergies are recorded in the InterRAI assessments, in the resident's file and on the medication charts. Indications for use for 'as required' medications were documented. These are improvements since the previous audit.</p> <p>On the day of audit, there was one resident self-administering his/her own inhalers. The resident has been assessed and competency signed off by the RN and the GP. Residents who self-administer medicines are monitored regarding timely administration.</p> <p>Controlled drugs are safely stored. Controlled drug register entries for one resident did not follow correct procedure and protocol.</p>
<p>Standard 1.3.13: Nutrition, Safe Food,</p>	<p>PA Low</p>	<p>The service has four-weekly rotating summer and winter menus. Food is prepared and cooked on site. Resident's dietary needs are identified on admission and these are communicated to the kitchen. Residents' likes</p>

<p>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>and dislikes and special dietary requirements are noted in the kitchen, but two diabetic nutritional profiles did not include special dietary requirements.</p> <p>Kitchen fridge, food and freezer temperatures are monitored and documented daily. A kitchen cleaning roster is implemented. The cook and the manager described how food stocks are rotated. Nine residents and two family interviewed confirmed that food services are discussed with the management and their likes and dislikes are catered for. Caregivers were observed serving and assisting those residents who required assistance with meals. Residents weights were monitored and nutritional supplements were available for residents as needed. A stock of nutritional supplements was kept in the kitchen.</p> <p>Special equipment is available as needed. Additional snacks are available for residents when the kitchen is closed such as sandwiches, biscuits, bread and fillings. Residents are offered fluids throughout the day.</p> <p>Staff have completed training in food safety and hygiene.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>All resident files sampled had a documented care plan and staff interviewed were familiar with the current needs of residents. Adequate dressing supplies were sighted in the treatment room. There are policies around wound management. An initial wound assessment and wound management plan was in place for one resident with a small skin tear. There is equipment readily available for pressure injury prevention. The team leader/RN described how to access a wound nurse specialist through the local DHB.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Short-term care plans reviewed documented appropriate interventions to manage short-term changes in health, such as infections. Monitoring forms are used, for example, observations, behaviour, blood sugar levels and neurological signs.</p> <p>Nine residents and two family members were interviewed and they were all complimentary of the care provided at Woodlands. Staff were considerate of residents' needs as observed by the auditors on the day of audit. The team leader/RN interviewed described the referral process and related form for referral to a wound specialist or continence nurse.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>FA</p>	<p>The activities programme is run by the diversional therapist (DT) who has been with the service for 15 years. She is supported by the staff in the dementia unit. The activities programme is planned monthly and advertised on the boards. Daily prompts of activities occur and residents from the dementia unit participate in rest home activities as appropriate.</p> <p>Resident's interests, hobbies and past experiences are identified on admission and these are used to develop an</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>individual activities plan. Resident files reviewed identified that the individual activity plan is reviewed at the care plan review. Activities are provided that are appropriate for the residents and reflect ordinary patterns of life.</p> <p>Community connections are maintained and outings are provided. Resident and family interview confirmed this occurs. The activities coordinator described 1:1 interactions and time spent with residents who are unable or prefer not to join in group activities.</p> <p>Resident meetings take place monthly and residents provide feedback on the programme about their likes and dislikes. Nine residents interviewed stated satisfaction with activities provided.</p> <p>Since the previous audit, the activities programme in the dementia unit has been updated. Description of each activity is documented and kept in a folder in the unit. Two caregivers interviewed confirmed that they understand their role in providing activities for residents and follow the activities programme planned by the DT. The required corrective action from the previous audit has been addressed.</p>
<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 plan evaluations reviewed were documented and have been completed at least six monthly. Residents and family are involved in reviewing care, and family interview confirmed this.</p> <p>Ongoing nursing evaluations occur as required and were included in the progress notes (link 1.3.6.1). Short-term care planning is used for chest infections and urinary infections, and management of wounds. Short-term care plans were reviewed and evidence sign off when the issue had been resolved or transferred into the long-term care plan. There is at least three monthly reviews by a GP.</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>The building holds a current warrant of fitness which expires in 4 April 2017.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an</p>	<p>FA</p>	<p>Call bells are placed in the residents' rooms, communal areas and shower/toilet areas. Call bells were tested in each area and they were all in working order. Residents and family interviewed confirmed that call bells are working and answered by the staff in a timely manner. Staff interview also confirmed that there were no issues around the call bell system and are all in working order. Therefore, the required corrective action has been</p>

appropriate and timely response during emergency and security situations.		addressed.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The clinical leader/RN collects infection control data monthly. The type of surveillance undertaken is appropriate to the size and complexity of this service. Infection control data was communicated to staff at staff meetings. Surveillance data included all infections and outcome of treatments. Residents' files evidenced the residents' who were diagnosed with an infection had a short-term care plan.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers including definitions. The clinical leader/RN is the restraint coordinator and is knowledgeable regarding this role. On the day of the audit there were no residents using a restraint or an enabler. All care staff interviewed could describe the difference between an enabler and a restraint.

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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>There is an annual education/training schedule in place. Not all mandatory training topics have been covered in the last two years. Annual performance appraisals were current in four of six files reviewed.</p>	<p>(i) There was no documented evidence of training in the last 2 years for the following topics; challenging behaviour, health and safety, cultural safety, falls prevention, end of life, skin management/pressure area.</p> <p>(ii) Annual performance appraisals have not been completed for the manager and the clinical leader/RN within the last 12 months.</p>	<p>(i) Ensure that training is completed and documented for the following topics; restraint, challenging behaviour, health and safety, cultural safety, treaty of Waitangi, complaints, open disclosure, falls prevention, end of life, nutrition/hydration, pain management, privacy/dignity, skin management/pressure area, sexuality/intimacy and spirituality/counselling.</p>

				<p>(ii) Ensure that performance appraisals are completed for the manager and the clinical leader/RN annually.</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</p> <p>Moderate</p>	<p>Ten medication records were reviewed (five rest home and five dementia). The service uses an electronic medication management system. General practitioners prescribe and review medications regularly. Medication is checked on delivery to the service and stored safely. Expired medications are returned to the pharmacy. Medication reconciliation is completed on admission and thereafter as required.</p> <p>Appropriate practice was observed during the medication round observed. However, review of the controlled drug (CD) register showed that electronic medication records and controlled drug register did not match for one resident's controlled drug administration</p>	<p>Review of the controlled drug register showed that a controlled drug entry was documented five times in one day as a 'prn controlled drug', but it was only signed twice in the electronic medication records. Progress notes also only had one record regarding administration of prn medication. The CD register has been checked by an RN after these recordings; however, the issue was not identified at the time.</p>	<p>Ensure safe administration of controlled drugs and recording is completed according to policies and procedures.</p> <p>30 days</p>

		records. All other controlled drugs were administered and recorded according to the recognised guidelines for residential aged care.		
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	Resident's dietary needs are identified on admission and these are communicated to the kitchen. Residents' likes and dislikes and special dietary requirements are noted in the kitchen, but two diabetic nutritional profiles did not include special dietary requirements.	Review of two diabetic nutritional profiles showed that sugar-free marmalade, jam, cakes, ice-cream and fruit juices be included in their food preferences. One of these residents was an insulin dependent diabetic. The kitchen did not have sugar-free food cakes, jam or other foods.	Ensure that residents' dietary needs are catered for. 180 days
Criterion 1.3.3.3 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.	PA Low	Five resident files were reviewed. Two of three rest home and one of two dementia files showed appropriate and timely documentation of each service provision.	(i) Two of five InterRAI assessments (one rest home, one dementia) were overdue. (ii) Care plan interventions are reviewed/updated prior to the InterRAI reassessment in two files reviewed (one dementia and one rest home).	(i) Ensure that InterRAI assessments are completed within required timeframes. (ii) Ensure that care plan interventions are updated/reviewed following an InterRAI assessment. 180 days

<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>Resident and family interviewed stated that residents' care needs are met. There is evidence of at least three monthly GP reviews or more often if required. There are service delivery gaps around access to podiatry services, care plan reviews and documentation around RN input.</p>	<p>Review of five resident's files identified gaps around service delivery interventions in three of five files; (i) One rest home resident with diabetes required podiatry services and has an ingrown toenail. This was identified in the resident progress notes as an issue but the resident has not been referred or seen by a podiatrist yet. Review of resident's notes and interview with the resident confirmed bleeding of the toenail at times and the most recently, his/her toenails were trimmed by a caregiving staff member. (ii) In one dementia file, the resident was transferred from the rest home to the dementia unit. Following an InterRAI assessment, care plan interventions were not updated. (iii) Review of resident's progress notes in one dementia and two rest home files showed lack of documented input from the RN following changes in health status and following administration of a 'prn medication'.</p>	<p>(i) Ensure that access to podiatry services are facilitated as required. (ii) Ensure that care plan interventions are updated following a significant change. (iii) Ensure that RN input is documented as required.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.