

Freeling Holt Trust

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 Audit (NZ) 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:	Freeling Holt Trust
Premises audited:	Freeling Holt House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 17 December 2014 End date: 18 December 2014
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:	31

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

Freeling Holt is a trust with a board providing a governance role. This surveillance audit was undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The service provides rest home and hospital level care for up to 32 residents with 31 residents during the audit. Some residents had physical disabilities and some were under the age of 65 years.

A manager has been in the role for a year. Staffing was appropriate to support the needs of residents. There was a quality and risk management programme in place that included review of incidents, complaints, implementation of an internal audit programme and a health a safety programme.

There were no improvements required at the last certification audit.

Improvements are required to the following: notifications following adverse events, integration of resident records, wound management, review of care plans, and documentation of administration of medication.

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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Staff were able to demonstrate an understanding of open disclosure with family informed when incidents occur. Information regarding access to advocacy services and how to lodge a complaint was available to residents and their family and complaints were investigated. Staff communicated with residents and family members following any incident.

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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Freeling Holt has implemented policies and procedures with a quality and risk management system that supported the provision of clinical care. The quality and risk management programme was monitored and included review of incidents/accidents, infections and complaints, internal audits, risk management and review of infection control surveillance data.

Experienced caregivers were rostered on to support resident needs and interviews with residents and relatives demonstrated that they had adequate access to staff when needed.

An improvement is required to ensuring that the general practitioner is notified in a timely manner following an adverse event.

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 organisation had systems and processes implemented to assess, plan and evaluate the care needs of residents requiring rest home or hospital level care. Staff were trained and qualified to perform their roles and to deliver all aspects of service delivery. The manager and charge nurse provided oversight of the care and management of all residents. All residents were assessed on admission using an InterRAI assessment with a care plan documented. The resident and family were involved in the care planning and review. The general practitioner ensured that all residents were seen on admission with follow up provided as per policy.

Improvements are required to the following: integration of resident records, wound management, review of care plans.

The activities were appropriate for residents with activities offered relevant to the needs and age of each resident.

Medication management systems were documented and all staff involved in medication management completed a competency assessment annually. An improvement is required to documentation of controlled drugs on the medication administration sheet.

Food services were outsourced. The menu plans were reviewed by a dietitian. Each resident was assessed by the registered nurse on admission for any identified needs in relation to nutritional status, with likes and dislikes documented. Meals were provided at appropriate times of the day. Residents interviewed and family reported satisfaction with the food service provided.

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.

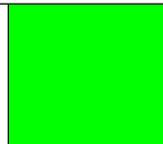


Standards applicable to this service fully attained.

There was a current building warrant of fitness displayed. Any maintenance issues were addressed as these arise. Residents and family described the environment as meeting their needs.

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 were adequately documented guidelines on the use of restraints and enablers and the management of behaviours of concern. No restraints or enablers were in use. Staff received training.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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A suitable programme for identification and surveillance of infections was implemented. Incidence and use of antibiotics was monitored and action taken to reverse any adverse trends.

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	1	3	0	0
Criteria	0	35	0	2	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures were in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and included timeframes for responding to a complaint. The complaints forms were available, with residents able to state where they can access these.</p> <p>A complaints register (index of complaints) was in place and included the date the complaint was received; the date the complaint was resolved and the number of the complaint. The evidence relating to each lodged complaint was held in the complaints folder.</p> <p>There was documented evidence of timeframes being met for responding to two complaints reviewed.</p> <p>Residents and family members stated that they would feel comfortable complaining.</p> <p>There has been one complaint forwarded by the Ministry of Health and the manager was responding to the issues raised.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Guidelines regarding open disclosure were documented and available to staff. Resident meetings are the venue for sharing of information between residents, staff and management. The residents report they are kept informed of matters that concern them. It was also reported by residents and family that management and staff are approachable and residents and family felt comfortable raising their concerns or needs.</p> <p>Family are informed if the resident had an incident, accident, had a change in health or a change in needs. This was evident in the 10 of 10 completed accident/incident forms sampled. Family contact was recorded in residents' files.</p> <p>A policy on interpreters is available if needed. The policy provided contact details of the local district health board interpreter services. The manager reported they have not had to use interpreter services to date.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Freeling Holt Trust is a charitable trust under the Charitable Trusts Act with a board of trustees providing a governance role (confirmed by the chairperson interviewed). The board included seven members who meet bi monthly with an annual general meeting. The board chairperson confirmed that meetings are held between the chair and the manager two weekly and as issues arise. Both the chairperson and the manager confirmed that any incidents or complaints are escalated to board level, as required.</p> <p>The manager provided operational management and had been in the role for a year. Prior to that, the manager was a charge nurse at the facility for two years. The manager is a registered nurse with a current annual practicing certificate.</p> <p>The mission, vision and goals of the facility were displayed and included in the welcome pack for a new admission.</p> <p>The facility provides care for up to 32 residents requiring rest home, hospital and physical disability level care with 31 residents living at the facility on the day of the audit. They included five requiring rest home level care and twenty-six requiring hospital level care. Of the 31 residents, there were 15 who identified as being young people with disability (under 65 years of age).</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>The service had a plan with objectives for 2014 documented. Goals had been</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>signed off as completed.</p> <p>The service implemented policies and procedures to support service delivery. All policies were reviewed and were linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. There was a document control system implemented to manage service documentation.</p> <p>Three caregivers and the charge nurse interviewed confirmed that they were kept informed of quality improvements with the following meetings in place three monthly: infection control, health and safety, staff, registered nurse and management. All aspects of the quality improvement and risk management programme were included through the meetings held. This included review of incidents, accidents, complaints, health and safety, audit reports and satisfaction surveys which took place annually. Corrective action plans were documented as issues were identified and there was evidence that these were signed off to indicate resolution of issues. There were resident meetings held throughout the year.</p> <p>The family/resident satisfaction survey completed in May 2013 and 2014 indicated that family and residents were satisfied with the service. The general practitioner also confirmed satisfaction with the service.</p> <p>The organisation had a comprehensive risk management programme in place. Health and safety policies and procedures were in place and a hazard register was documented with evidence that any hazards identified were signed off as addressed or risks minimised or isolated.</p> <p>The service was benchmarking data with this discussed at management and registered nurse meetings.</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>PA Moderate</p>	<p>The manager was aware of situations where the service would be required to notify statutory authorities. Notifications to external authorities had not been required since the last audit; however there was insufficient evidence that the GP had been contacted following an adverse event which resulted in injury to a resident.</p> <p>There was a system in place to document, investigate and monitor all adverse events. The adverse reporting process enabled service shortfalls to be identified and corrective actions implemented. Half of all incidents for 2014 were infections, with the remaining made up of falls, equipment malfunction and behaviours of</p>

		<p>concern. An adverse events log was maintained and collated annually.</p> <p>Staff received education at orientation on the incident and accident reporting process. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The organisation employed 31 staff. This included the manager, charge nurse, registered nurses and caregivers who complete all cares and support for residents along with household tasks. A selection of staff files were sampled.</p> <p>The skills and knowledge required for each position were defined in the job descriptions and terms of employment. Responsibilities, roles, functional relationships, person specifications (including qualifications) and objectives were included.</p> <p>Recruitment requirements were met. Reference checks and police checks were conducted. A register of professional qualifications was maintained. All staff completed an orientation. An orientation competency check list was used. Competency requirements were defined and monitored. This included medication competencies.</p> <p>Mandatory training requirements were defined and included the Health and Disability Standards and district health board contract requirements. Training records were maintained. Training records sampled confirmed good attendance.</p> <p>Performance appraisals were conducted annually. The completion of performance appraisals was confirmed in all by one staff file sampled. This was scheduled but did not take place as the staff member was on leave for a month when the appraisal was due. The appraisal had been rescheduled to occur within the coming month.</p> <p>Agency staff were used when required. An orientation booklet was provided for agency staff which included the essential components of service delivery. The manager reported they only use one agency with preferred staff that were familiar with the service.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe</p>	FA	<p>The staffing policy was the foundation for work force planning. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or</p>

<p>service from suitably qualified/skilled and/or experienced service providers.</p>		<p>as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy.</p> <p>There were caregivers allocated to support residents (five in the morning, four in the afternoon and two caregivers overnight). There was at least one registered nurse on duty at all times. Absence was replaced by part time staff working extra shifts.</p> <p>Residents and families interviewed confirmed that staffing was adequate to meet the residents' needs.</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 Low</p>	<p>Resident medication files included a signature verification log. There was a current list of all staff who were competent to administer medications inclusive of the manager. Medication competencies were completed annually (sighted in staff files reviewed). Education was provided to all staff annually at least.</p> <p>The controlled drugs were stored as per legislative requirements and were checked weekly by the registered nurse and another staff member. Administration of controlled drugs was recorded in the controlled drug register and on the administration sheet. One file reviewed did not include correct documentation of a controlled drug on the administration sheet.</p> <p>The standing orders were not documented correctly on the first day of the audit however they were updated by the general practitioner (GP) by the second day of the audit. The medication record sheets were signed off by the registered nurse when checked in from the pharmacy. There is evidence of the GP writing each individual medication and signing with commencement date and signature for each entry. The medications were reviewed three monthly or sooner if required.</p> <p>Photo identification was on each individual page of the medication records. Allergies and any sensitivities were recorded accurately on the medication record and the medical notes.</p> <p>Evidence was seen of a process of prescribed medication being returned to the pharmacy when it was out of date or not required. The GP worked effectively with the contracted pharmacist and the registered nurse who was responsible for the medicine management as stated by the general practitioner and the charge nurse.</p> <p>There were no residents that self-administer medication. There is a process</p>

		documented should this be required.
<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>	FA	<p>Food services were outsourced to an external company. Cooks had food safety certificates and oversight was provided by the regional manager (confirmed by the regional manager interview during the audit).</p> <p>An individual dietary assessment was undertaken when each resident is admitted to the service by the registered nurse. Any identified individual needs and preferences were recorded. Residents were weighed on admission, monthly and as changes in state indicate. Any residents who experience weight loss or require to weight gain were discussed with the GP and the registered nurse and the staff including kitchen staff were informed of any requirements.</p> <p>The menu plans were reviewed by a contracted New Zealand registered dietitian.</p> <p>Temperatures of the fridge and freezer were maintained by kitchen staff and records indicated that these were within normal range. There was a white board to remind staff of any special diets or requirements for residents. Special days were celebrated. The Christmas menu was delivered on the day of the audit.</p> <p>Infection control in the kitchen and audit requirements are effectively met. Chemicals and food products were stored appropriately and safely at all times.</p> <p>Residents interviewed and families were very satisfied with the food provided.</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>	FA	<p>In the resident files reviewed there was evidence of the needs of residents being assessed in line with their aims stated with all residents now having an InterRAI assessment. This included remaining as independent as possible and being included in all care decisions as possible. The residents reported on interview that they were involved in their care and felt they are treated as an individual. Residents under the age of 65 years stated that they were encouraged to be independent and there were activities that fit their needs.</p> <p>The families interviewed stated that their family members were well cared for and all enjoyed the size of this facility and the care provided. Families stated that they can arrange to talk to the manager at any time.</p> <p>The staff reported that they know the residents individually and they ensure they work within the resident's care plans, which were based on the resident's needs</p>

		<p>(refer 1.3.8).</p> <p>There were short term care plans documented when issues arose that require short term interventions.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme was set by the lifestyle coordinator. The residents were engaged in the community as much as possible. There were differences in the activities programme for younger people with younger residents stating that these included swimming, spa pool, attending community events such as the food show, visiting Browns Bay cafes etc.</p> <p>Other activities were planned such as exercises, music sessions, bingo, bowls and other activities. Some residents attended church services in the community and church services were held on site.</p> <p>Activities were planned to develop and to maintain strengths, skills, and interests that are meaningful to the individual residents. Residents interviewed enjoyed the activities programme and were aware that it is voluntary to attend.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Moderate	<p>Long term care plans were expected to be reviewed every six months or earlier as required. Progress notes were signed each duty by caregivers and with input from the registered nurse. Evidence was seen of the family/whanau involvement in the care reviews.</p> <p>In some of the files reviewed evidence was seen of the care plan being updated if an event occurred that was different from expected. It was also recorded when staff contacted family. Family interviewed verified this does occur.</p> <p>The residents at interview each verified that they were given the opportunity to be involved with all aspects of their care and reviews.</p> <p>The service has focused on completing assessments for residents using interRAI. Care plans have been documented and these were in the process of either being reviewed or they have been reviewed.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>A current building warrant of fitness is posted at the entrance to the facility (expiry date 21 June 2015). There have been no building modifications since the last</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>audit.</p> <p>There is a maintenance schedule implemented with refurbishments completed as required. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. The areas are suitable for residents with mobility aids. There are small rooms/withdrawal spaces for residents.</p> <p>External areas are provided to accommodate residents using mobility aids including wheelchairs. Gardens include areas for residents to be involved in planting and weeding.</p> <p>The following equipment is available: chair scales, shower chairs and lifting belts. There is a test and tag programme and this is up to date.</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>	<p>FA</p>	<p>The infection control surveillance programme was appropriate to the size and scope of the service. All infections were recorded and collated monthly. This included a full analysis of all infections over that period. Surveillance data was externally bench marked in order to make meaningful comparisons with similar services. Where results showed an increase, this was investigated and actions recorded. This was confirmed in management meeting minutes sighted. Corrective actions were documented and monitored. Minutes of the quarterly management and infection control meetings were also sampled. A full review and analysis of all infections was also provided to the general practitioner every six months. This was sighted (April-September 2014).</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>A restraint free environment was promoted. The service had no restraints in use at the time of audit. Related policies and procedures met the required standards. Staff education was provided and offered during orientation and as part of the in-service programme. Education included management of behaviours of concern. Staff interviewed were aware of the difference between a restraint and an enabler and when they might apply.</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 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	<p>PA Moderate</p>	<p>Ten incident reports were sampled. Reporting requirements were met in all but one of the incidents. In the said event, the resident had received a minor injury. First aid was provided, the resident was monitored and the family member was contacted. Staff were given the opportunity to debrief following the incident and a full investigation was conducted. The resident’s GP was not notified at the time and did not review the resident until the following week. GP records and progress notes sampled confirmed that the injury was not serious, had been monitored appropriately, was healing and no further intervention was required.</p>	<p>Essential reporting following an adverse event had not occurred in a timely manner. For example: notifying the GP following injury.</p>	<p>Notify the residents’ GP (in a timelier manner) if an injury occurs following an incident.</p> <p>60 days</p>
<p>Criterion 1.3.12.6</p>	<p>PA Low</p>	<p>Administration of controlled drugs was</p>	<p>Documentation of administration</p>	<p>Document</p>

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.		recorded in the controlled drug register and on the administration sheet. One file reviewed did not include correct documentation of a controlled drug on the administration sheet however it was correctly documented on the controlled drug register and the balance of the drug was correct when checked. The sample size was increased to include one other resident file with controlled drugs recorded. On this instance, the administration sheet and controlled drug register were correctly recorded.	of controlled drugs is not always recorded accurately on the administration sheet.	administration of controlled drugs accurately on the administration sheet. 30 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 Moderate	Wound management was documented in a word document. One resident (tracer 3) had multiple wounds and assessments were complete for some of the wounds. All had a plan documented and some had progress notes documented.	Not all wounds for one resident had an assessment completed and progress notes were not consistently documented for one wound. Progress notes did not always differentiate progress against individual wounds.	Document assessments for all wounds and evidence of progress against each wound when a resident has multiple wounds. 30 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Documentation of assessment, plans and review of wound management was completed on a document for each resident in word on the computer. The long term care plan is expected to refer to each wound.	The lack of integrated notes makes it difficult for staff to read all information around wound management and the care plans do not reference strategies for all wounds.	Develop a coordinated approach to service delivery for management of wounds for each resident with multiple wounds. 180 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate	PA Moderate	Long term care plans are expected to be reviewed every six months or earlier as required. Evidence of a full review documented six monthly is sighted in three of	Evidence of a full review documented six monthly is not sighted in two of the five files	Review care plans six monthly as per policy.

the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.		the five files reviewed.	reviewed.	90 days
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA</p> <p>Moderate</p>	In some of the files reviewed there was documentation of changes in state of a resident as these occur.	The care plan was not always updated when changes occurred outside of a six monthly review period.	<p>Update the care plan as changes occur for a resident.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.