

Karaka Court Limited - Woodlands of Feilding

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 Feilding	
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 22 January 2016	End date: 22 January 2016
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:	33	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Woodlands of Feilding provides care for up to 39 residents across two service levels (rest home and hospital). On the day of audit there were 21 rest home residents and 12 hospital residents.

The service is managed by an experienced manager who has been in the role for seventeen years. The manager is supported by a clinical leader (registered nurse) and she has been in the post since 2009. There is a team of registered nurses who have experience within the aged residential care environment.

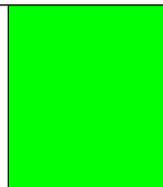
This surveillance audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with relatives, staff and management.

The service has addressed eight of nine shortfalls identified at the previous audit relating to the consent process, policies and procedures, quality processes, education, the admission agreement, restraint and the environment. Further improvements are required around assessment processes.

This audit has identified that improvements are required relating to corrective action plans and communication following internal audits, care plan interventions and evaluations and medication documentation.

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.

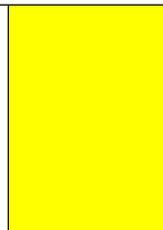


Standards applicable to this service fully attained.

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Interviews with residents and relatives confirm family are kept informed of their family member's current health status including any adverse events. There is a complaints policy to guide practice.

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.

The service continues to implement a quality and risk management framework that includes management of incidents, complaints and infection control surveillance data. There is an implemented internal audit programme to monitor outcomes. There is an appropriately experienced manager who provides guidance for the service and is supported by a clinical leader and experienced care staff. There is an education plan that includes all required education as part of these standards. The service has sufficient staff allocated to enable the delivery of care.

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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Residents are assessed prior to entry to the service. A baseline assessment is completed upon admission and paper based assessments are undertaken within three weeks. Long-term care plans are developed by the service's registered nurses who also have the responsibility for maintaining and reviewing the plans.

InterRAI assessment tools are in the process of being implemented. Long-term plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.

The activity programme is varied and reflects the interests of the residents including community interactions.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management using the computerised medication system. Competencies are completed. Medication profiles are up to date and reviewed by the general practitioner three monthly or earlier if necessary. The menu is designed and reviewed by a registered dietitian. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Regular audits of the kitchen occur.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service displays a current building warrant of fitness which expires on 1 September 2016.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There are four residents with restraint. Staff are trained in restraint minimisation, challenging behaviour and de-escalation techniques.

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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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. 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 in a timely manner.

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	16	0	3	1	0	0
Criteria	0	41	0	3	1	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>In the resident files sampled they were current admission agreements on file. The previous audit finding has been addressed. Five resident files sampled all included consents and resuscitation directives.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice. The manager leads the investigation and management of complaints (verbal and written). There is a complaints (and compliments) register. Complaints are discussed at the monthly staff meeting. There have been no complaints made in the year 2014 and 2015. There have been a number of compliments that have been received across the 2015 period. Discussion with residents (one hospital and three rest home) and relatives confirm they are aware of how to make a complaint. The complaints procedure is provided to residents within the information pack on admission.</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>There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Eight of eight incident forms reviewed identify family were notified following a resident incident. Interviews with staff confirm that family are kept informed. Three families interviewed (one rest home level and two hospital level) confirmed they were notified of any changes in their family member's health status.</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>Woodlands of Feilding provide care for up to 39 residents across two service levels (rest home and hospital). On the day of audit there were 21 rest home residents including one younger person and 12 hospital residents. There were no respite residents.</p> <p>There is a 2016 Business Plan that covers both the Feilding and Palmerston North facilities and outlines objectives for the period. There is an established and implemented quality programme.</p> <p>The service is managed by a full-time manager (non-clinical) who reports through to the director (owner) monthly. The manager is supported by a clinical leader who is a registered nurse. There is a team of registered nurses who have experience within the aged residential care environment.</p> <p>The manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>Woodlands of Feilding is implementing a quality and risk management system. There are policies and procedures to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff. Policies and procedures align with current practice. The clinical leader collates incident and infection data. Data is recorded accurately and is reported at staff meetings (sighted). The previous audit findings have been addressed.</p> <p>Quality matters are taken to the monthly staff meetings and also discussed at monthly registered nurse meetings. There are monthly resident meetings. Meeting minutes demonstrate key components of the quality management system and are discussed including internal audits, infection control, incidents (and trends) and in-service education. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicate issues raised are followed through and closed out, including resident meetings (monthly).</p>

		<p>Woodlands of Feilding is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are seen to be resolved at the time. Internal audit results are communicated to staff at the staff and registered nurse meetings.</p> <p>Residents are surveyed to gather feedback on the service provided. Outcomes of the survey have not been fully communicated to residents and families.</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>	FA	<p>The service collects incident and accident data and reports aggregated figures monthly to the staff meeting. Incident forms are completed by staff and the resident is reviewed by a registered nurse. The clinical leader (RN) is also available after-hours, if required. Family are notified by either the clinical leader or registered nurses. Eight incident forms were reviewed. All had been completed appropriately. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.</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>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files were reviewed (one manager, one clinical leader, one cook, one diversional therapist, one registered nurse and two caregivers) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed.</p> <p>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 (sighted in files reviewed). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an education plan that includes all required education as part of these standards. Interviews with staff confirm that training is provided. A competency programme is in place with different requirements according to work type (e.g. caregiver, registered nurse and kitchen). Core competencies are completed and a record of completion is maintained, with signed competency questionnaires sighted in files reviewed. Lifting training was completed in August 2014 and infection control staff training was completed in May 2015. The previous audit finding has been addressed</p> <p>There is a staff member with a current first aid certificate on every shift.</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>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows: four caregivers in the morning (varying times), four during the afternoon (varying times) and one on night shift (2300-0730). There is at least one registered nurse and one first aid qualified person on each shift. The manager and clinical leader are both on call. The caregivers, residents and relatives interviewed inform there is sufficient staff on duty at all times.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents are assessed prior to entry to the service by the needs assessment team and an initial assessment is completed on admission. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code of Consumer Rights, advocacy and complaints procedure.</p> <p>There is an admission booklet available to all residents on enquiry or admission. Registered nurses interviewed were able to describe the entry and admission process. The GP is notified of a new admission.</p> <p>Five signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract. Exclusions from the service are included in the admission agreement. This is an improvement on the previous audit.</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>	PA Low	<p>There are medication management policies and procedures in place which follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: medicines care guides for aged residential care. There is a locked medication room and all medications are stored securely. Medications are checked as part of a monthly medication audit. Equipment such as oxygen and suction is routinely checked. All eyes drops were noted to be dated at opening. No expired medications were noted on any trolleys or medication storage shelves.</p> <p>A medication round was observed; the procedure followed by the registered nurse was correct and safe.</p> <p>The service has implemented a computerised medication system. The use of the system to enable correct signing for medication administration has not been fully developed.</p> <p>The self-medicating policy includes procedures on the safe administration of medicines. There are currently no residents who self-administer. .</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	FA	<p>There is a full kitchen service and all meals are cooked on site. Fridge, freezer and meal temperatures are recorded and action taken as needed. The kitchen was observed to be clean and well organised. Meals</p>

<p>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>are serviced in a separate dining room and meal services were observed to be managed well.</p> <p>A full dietary assessment is completed on all residents at the time they are admitted. The kitchen is alerted of any special diets, likes and dislikes, or meal texture required. The cook was able to discuss residents and their dietary needs. Resident meetings discuss food as part of their meetings. Residents and family members praised the meals. A registered dietitian reviews the menu annually.</p> <p>Special equipment is available, such as lipped plates, assist cups, grip and built up spoons.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Low</p>	<p>All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. The initial nursing assessment is completed within twenty-four hours of admission for all five files reviewed and the long-term care plan is completed within three weeks.</p> <p>All RNs are interRAI trained and the process of assessing residents with interRAI has commenced. None of the five files reviewed evidenced an interRAI assessment, all residents had comprehensive paper based assessments. The service states that eight residents now have their first interRAI assessments.</p> <p>Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan.</p> <p>The previous audit found that resident weights had not been recorded and not all resident had been assessed fully on admission. This has now been addressed.</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>The care being provided is consistent with the needs of residents as demonstrated by discussion with the GP, family, residents, staff and management.</p> <p>Review of long-term care plans evidences gaps in care plan interventions.</p> <p>Dressing supplies are available and a treatment room is stocked for use in each of the three units.</p> <p>Continence products are available and resident files include 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.</p> <p>Continence management in-service and wound management in-service has been provided as part of annual training. Registered nurses interviewed were able to describe access to specialist services if required.</p> <p>The wound care plan folder documents four residents with wounds - two chronic wounds and two skin tears</p>

		<p>although one resident has two wound plans on one form. There are no documented pressure injuries. All of these wounds have documented assessments and a treatment plan in place.</p> <p>The management of smaller wounds are not filed with the main wound file and the documentation is incomplete.</p> <p>Short-term care plans are in place for a range of short term and acute conditions such as infections and wounds. Registered nurses interviewed were aware of the need to complete a short-term care plan following an acute event (falls for example) and for changes in the residents condition.</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>Woodlands of Feilding employ a trained diversional therapist (DT) who works Monday to Friday. A monthly activities programme is published each month. There is a wide range of activities offered.</p> <p>On or soon after admission, an activities assessment and social history (This Is My Life) is taken and information from this is incorporated in to the resident's individual activities plan. This is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes are completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan.</p> <p>The service owns a van. The DT has a current first aid certificate. Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. Resident meetings are held monthly and feedback on the activities programme is encouraged at the meetings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans are reviewed and resident care is evaluated six monthly for rest home residents and three monthly for hospital residents. This was evidenced on all resident files reviewed. Three and six monthly reassessments are paper based with the service moving towards interRAI (Link to 1.3.4.2). Documentation of GP visits were evident that reviews were occurring at least three monthly.</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>	FA	<p>The service displays a current building warrant of fitness which expires on 1 September 2016. Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. The previous finding around repairs to a shower has been rectified.</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>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections. Individual short-term care plans are available for each type of infection. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly. Outcomes and actions are discussed at the monthly quality staff meetings.</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>The service is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with the registered nurses and caregivers. There are four residents with restraint and no enablers and all document regular review.</p> <p>There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures.</p> <p>Restraint minimisation procedures include: the approval process, assessment, recording/documenting use (consent), reducing the risks, evaluation, monitoring and quality review of use. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Restraint minimisation procedures include: the approval process, assessment, recording/documenting use (consent), reducing the risks, evaluation, monitoring and quality review of use. Staff are trained in restraint minimisation, challenging behaviour and de-escalation. The assessment forms have been updated since the previous audits and now include areas for consideration from A to H. Two resident files reviewed with restraint, both included a documented assessment process. This is an improvement on the previous audit.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	Residents are surveyed to gather feedback on the service provided. The resident food satisfaction survey result for June 2015 showed an overall satisfaction rate of 96% and the resident satisfaction survey result for August 2015 showed an overall satisfaction rate of 86%. Outcomes of these surveys have not been provided for residents and families.	The results and outcomes of the food satisfaction survey completed in June 2015 and the resident care survey completed in August 2015, have not been communicated to residents and relatives.	<p>Ensure the outcomes of the resident food satisfaction and resident care survey results are communicated to residents and families.</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,</p>	PA Low	There are policies and procedures in place to guide staff including operating process and procedures for the computerised medication system.	A review of ‘not administered’ medications on the electronic system evidences that the staff do not appropriately document when they give medications. Triangulation of the ‘administered list’ with ten residents evidences that medications are given as	Ensure that staff who administer medications document this correctly on the computerised medication system

storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.			prescribed.	60 days
<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>	PA Low	The service uses a wide range of paper based assessment tools both on admission and at least six monthly. These are reflected into care plans. The interRAI assessment tool was not evident in the sample of files reviewed.	The service has yet to fully implement the interRAI assessment process for all new and existing residents. One of five resident files reviewed (rest home) was admitted after 1 July 2105. The file sample was extended to review two more recent admissions (one rest home and one hospital). None of the three recent admissions had been assessed with the interRAI tool.	<p>Implement the interRAI tool for resident assessment following admission and for six monthly reassessment and evaluation of care</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>	PA Moderate	Five resident files were reviewed. Four had been admitted for over six months. These four all had six monthly assessments or more often in place that linked to care plans. Care plan interventions are personalised. There is a process for wound plans where larger wounds are kept in a wound care file and 'smaller wounds' are filed in the residents own file. Documentation was incomplete for wound care management.	i) One hospital resident does not have interventions recorded for identified choking risk and for care of a chronic wound; ii) there is documented list of residents with 'smaller wounds'. Of the smaller wounds reviewed (three skin tears): one does not have the size of the wound documented, two have no dressing instructions and one has no documented evaluation; and iii) One resident has two wounds documented on one form.	<p>i) Ensure that all identified resident risks are included in the resident care plans; ii) Formalise a process for the recording of all identified wounds and ensure that all wounds have a documented management plan and are evaluated; and iii) Ensure that each wound has its own wound management plan</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.