

Kerikeri Village 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 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:	Kerikeri Village Trust
Premises audited:	Kerikeri Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 7 June 2016 End date: 16 June 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:	61

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

Kerikeri Retirement Village is owned and operated by a community trust. Kerikeri Retirement Village cares for up to 68 residents requiring hospital, rest home and dementia level care. On the day of the audit, there were 61 residents.

This unannounced surveillance audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, review of residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner. The audit was conducted over two separate days due to auditor availability. The audit also included assessing the service as suitable to provide hospital level care for two additional residents in two single rooms.

The facility manager retired one week prior to the audit. A new facility chief executive has been appointed. The acting general manager (clinical manager) is ably managing the facility, having worked in a senior management role at the service for many years. A quality and risk coordinator and an acting clinical manager support her.

Residents and family interviewed spoke positively about the service provided.

Ten of twelve previous shortfalls have been addressed. These were around open disclosure, complaint documentation, quality management including corrective action planning, staff training, initial care plans, activities plans, evaluations and medication management including self-administration competencies. Improvement continues to be required around assessments and care interventions.

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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Policies are implemented to support residents' rights, communication and complaints management. Residents and families are kept informed following an adverse event. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The acting manager is a registered nurse who has worked at the facility as the clinical manager for the past seven years. An assistant clinical manager, registered nurses and other care staff support her. Strategic goals provide direction. The quality and risk management programme is established and implemented. Meetings are held to discuss quality and risk management processes. Residents meetings are held regularly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are managed appropriately. There is an education and training programme in place. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster reflects sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness. Two new rooms are suitable for hospital level care.

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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A documented definition of restraint and enablers aligns with the definition in the standards. There were seven residents requiring restraint and three residents with identified enablers. Enabler use is voluntary.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Kerikeri Retirement Village has an infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

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	14	1	0	2	0	0
Criteria	0	37	1	0	2	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>A complaints procedure is provided to residents within the information pack at entry.</p> <p>Written information on the service philosophy and practices particular to the dementia unit is included in the information pack.</p> <p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission.</p> <p>A complaints register was up to date. This is an improvement from the previous audit. Verbal and written complaints are documented with two complaints reported since the previous audit. Complaints were investigated, timelines for responding to the complaints were met and the complaints were resolved.</p> <p>Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed (the chaplain/diversional therapist, seven caregivers [three from the hospital, two from the rest home and two from the dementia unit], three registered nurses (RN), two activities coordinators and the acting clinical manager) were able to describe the process around reporting complaints.</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>Residents interviewed (three from the hospital and two from the rest home) stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were viewed. The forms include a section to record family notification. All ten forms indicated family were informed. This is an improvement from the previous audit. Relatives interviewed (one from the rest home, one from the hospital and two from the dementia unit) confirmed they were notified of any changes in their family member's health status.</p> <p>Interpreter services are available through the DHB if required. Staff and family assist as interpreters if needed.</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>Kerikeri Retirement Village is owned by a community charitable trust. A board of trustees undertakes governance. The general manager has recently retired and an acting manager (who is the clinical manager/RN) has assumed this role until 11 July. After the 11th July, the new chief executive officer (CEO) begins her appointment. The new CEO has experience managing non-profit community organisations. An assistant clinical manager (RN) supports the acting manager/RN.</p> <p>The service can provide care for up to 68 residents. There is 23 rest home (this includes two double rooms that are currently single occupancy), 26 hospital beds and 15 beds in a secure dementia unit. This audit included verifying two new single rooms as suitable for providing hospital level care. On the day of the audit, there were 62 residents (17 rest home level, 30 hospital level and 15 residents in the secure dementia unit). Four residents' rooms are dual-purpose and located in close proximity to the nurses' station. There was one resident (hospital level) under the young person with a disability (YPD) contract and two respite level residents (one dementia level and one hospital level).</p> <p>Kerikeri Retirement Village has a documented vision and philosophy that is posted in a visible location at reception. The 2016-2020 business plan describes the organisation's strategic goals.</p> <p>The acting manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility. She recently</p>

		attended a one-day leadership course provided by the Aged Care Association.
<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>	FA	<p>A 2016 quality and risk management programme is in place. This programme has been updated since the previous audit and there is a quality and risk coordinator (RN). A second RN supports the quality and risk coordinator for one day a week. Interviews with management and staff reflect their understanding of the quality and risk management systems.</p> <p>Policies and procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are reviewed regularly. Policies and procedures have been updated to include reference to InterRAI for an aged care service. New policies or changes to policy have been communicated to staff, evidenced in staff meeting minutes.</p> <p>Data collected (falls, medication errors, wounds, skin tears, challenging behaviours), is collated and analysed, with results communicated to staff. Internal audits reviewed have been completed as per the internal audit schedule. Any area of non-compliance includes the implementation of a corrective action plan when implemented. These are improvements from the previous audit.</p> <p>Quality initiatives have been implemented including a new call bell system and close monitoring of medication errors. The purchase of a new call bell system was in response to residents' concerns around the timeliness of responding to call bells (resident satisfaction survey results Feb 2016). An RN oversees monitoring of medication errors (weekly), more frequently. Corrective actions implemented over the past two months have resulted in a significant reduction in the number of medication errors. Health and safety is well-managed. Falls prevention strategies include a comprehensive investigation of residents' falls on a case-by-case basis, to ensure that strategies to reduce falls have been implemented.</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</p>	FA	<p>An accidents and incidents reporting policy is being implemented. Ten accidents/incidents were randomly selected for review. All ten clinical events were investigated by the acting manager/RN or assistant clinical manager/RN. Adverse events are linked to the quality and risk management programme. Staff are kept well-informed. There is evidence to support actions are undertaken to minimise the</p>

<p>family/whānau of choice in an open manner.</p>		<p>number of incidents.</p> <p>Discussions with the acting manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. HealthCERT was recently informed following an adverse event around a resident with challenging behaviours. A gastro outbreak in February was appropriately managed with the public health authorities notified in a timely manner.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Negligible</p>	<p>There are human resources management policies in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of current practising certificates are retained. Seven staff files were reviewed (two RNs, four caregivers, one cleaner) and confirmed that reference checks were completed before employment was offered. Signed employment agreements and job descriptions are retained in staff human resources files.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme is being implemented. Fifteen caregivers work in the dementia unit. Twelve caregivers have completed their dementia qualifications and have been employed for more than one year. Three caregivers are in the process of completing and have been employed for less than one year. This is an improvement from the previous audit. Nursing staff attend external training provided by the DHB. The service has not been able to secure training to have sufficient InterRAI trained staff to meet contractual requirements. The service has commenced using the InterRAI tool. However, the manager reports that difficulty in accessing InterRAI training for staff means that the service has been unable to meet all InterRAI contractual obligations. This aspect of the finding is deemed to be negligible risk. Staff are appraised a minimum of annually on their performance.</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 staffing policy describes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. Staffing levels have recently increased on the hospital wing to accommodate two additional hospital-level beds. The quality and risk coordinator/RN has increased hours worked from two days a week to three days per week and is supported by another RN one day a week.</p>

		<p>At least one registered nurse is on-site at any one time, with adequate numbers of caregiver staff to support them. Activities staff are available in the dementia unit for two hours a day, seven days a week. Volunteers assist with the activities programme for residents. Extra staff can be called on for increased resident requirements.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>On arrival from the pharmacy, an RN checks medications against the resident's medication profile. Any mistakes by the pharmacy are regarded as an incident.</p> <p>Medications are stored and checked according to guidelines and legislative requirements, including those which require greater controls. This is an improvement since the previous audit.</p> <p>Designated staff are listed on the medication competency register, which shows signatures/initials to identify the administering staff member. Two registered nurses were observed safely and correctly administering medications.</p> <p>Resident medication charts are identified with demographic details and photographs. The medication fridges have weekly temperature checks. All 10 medication charts had allergies (or nil known) documented.</p> <p>All medications are stored appropriately.</p> <p>One rest home resident self-administers medication. A competency assessment has been completed and reviewed. This is an improvement since the previous audit.</p> <p>All 10 medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed. All medication charts indicate that medication is administered as prescribed. All medication charts sampled documented the indication for giving the PRN medication. This is an improvement since the previous audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>The service has a large workable kitchen. The kitchen and equipment are well maintained. The service employs sufficient kitchen staff to provide meal services over seven days a week. A rotating four weekly menu is designed by a dietitian.</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed.</p> <p>Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.</p> <p>The residents interviewed spoke positively about meals provided and they all stated that they are asked by staff about their food preferences.</p> <p>The service regularly checks food in both the fridge and freezers to ensure it is disposed of when the use by date expires. All food is stored and handled safely. Food and fridge/freezer temperatures are recorded. The kitchen is clean.</p> <p>Kitchen staff have been trained in safe food handling.</p> <p>The service provides additional nutritious snacks for residents in the dementia unit that are readily available over 24 hours.</p> <p>The service can cater for an additional two residents in the hospital.</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 Moderate</p>	<p>The previous audit identified that not all resident files reviewed had risk assessments reviewed six monthly. The five files reviewed for this audit identified that paper-based assessments had been completed within three weeks of admission (following an initial assessment in the first 24 hours). Not all InterRAI assessments had been completed, as contractually required. One of three resident files (where the resident had been at the service longer than six months), had not had the risk assessments reviewed six monthly. One resident with behaviours that challenge did not have a behaviour assessment. The previous shortfall around assessments continues to require improvement.</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. Not all of the care plans had documented interventions for all identified needs. This previously identified shortfall continues to require improvement. The use of short-term care plans was evident with one exception. In all files sampled, the residents were receiving care that meets all their needs as reported by staff. Regular turns and behaviour monitoring were not always documented. Regular weight checks and weight management plans, food and fluid records and bowel records were maintained. The GP interviewed stated the facility applied changes of care advice immediately and was</p>

		<p>complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident's primary care is provided by their own GPs.</p> <p>Dressing supplies are available and a treatment room stocked for use. Wound documentation requires improvement. In addition to pressure injuries and skin breakdown (see 1.3.3), there were eight skin tears, two lacerations, five ulcers (all one resident), one unidentified wound, one surgical wound and three lesions. The previously identified shortfall around wound management continues to require improvement.</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.</p> <p>Specialist continence advice is available as needed.</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>	<p>FA</p>	<p>The recreational coordinator (the chaplain) has worked at the service for 14 years. Three additional activity officers work across all service levels and are all in the process of completing diversional therapist training. Additionally, 70 volunteers support the programme and the chaplain (who is a trained diversional therapist) and all have had a police check and an orientation. The volunteer coordinator organises the volunteers. All recreation/activities assessments and reviews are up to date. Residents were observed being actively involved in a variety of activities in the lounges (in each area) and throughout the facility. Residents have a comprehensive assessment completed over the first few weeks after admission and a complete history of past and present interests, career and family is obtained.</p> <p>Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Regular outings occur and there is strong community engagement.</p> <p>All residents and family members interviewed stated that activities are appropriate and varied and spoke positively about the programme.</p> <p>Four of five resident files identified that the individual activity plan is reviewed at the time of the care plan review (one resident was on respite care). The resident file from the dementia unit had an activity plan over 24 hours. This is an improvement since the previous audit. Caregivers in the dementia unit assist with activities over the weekend and evenings. The programme observed was appropriate for older</p>

		people with mental health conditions.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans in files sampled were developed by an RN within three weeks of admission and evaluated at least six monthly or if there is a change in health status. This is an improvement since the previous audit. There are at least three monthly reviews by the GP. Changes in health status are documented and followed up (link 1.3.6.1 for exceptions). General practitioners review residents' medication at least three monthly or when requested if issues arise or health status changes.</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>There is a current building warrant of fitness.</p> <p>This audit has assessed two additional rooms in the hospital wing as suitable for use. The rooms are large with ensuites and a new small lounge/communal area has been developed near the new rooms.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control coordinator collates infection data monthly. This data is reported to the facility meetings. The service submits data monthly for benchmarking against other similar facilities. A gastro outbreak (not norovirus) in February 2016 was appropriately managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service philosophy around restraint is that it is used as an intervention that requires a rationale and is a last resort when other interventions or calming/defusing strategies have not worked.</p> <p>There were three residents with enablers and seven with restraints (all hospital). Two enabler files sampled and interview with one resident using an enabler, provided evidence that enabler use is voluntary.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Negligible	The service has commenced using the InterRAI tool. However, the manager reports that difficulty in accessing InterRAI training for staff means that the service has been unable to meet all InterRAI contractual obligations. This aspect of the finding is deemed negligible risk.	Two of three resident files where an InterRAI assessment was contractually required (one dementia and one rest home), had not had these completed. This is due to the resignation of a trained InterRAI assessor. The provider has taken steps to replace a trained assessor, however, the scheduling of training for the new staff, which is beyond the control of the provider, has led to a delay in the carrying out of InterRAI assessments.	<p>Ensure that contractual obligations around InterRAI are met.</p> <p>180 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment</p>	PA Moderate	All resident files sampled had an initial assessment completed on the day of admission and the four long-term files had a suite of paper-based assessments completed, with the exception of a	<p>(i) The dementia tracer file had behaviours that challenge but no behaviour assessment had been completed.</p> <p>(ii) One resident file (rest home tracer) had not had risk assessments reviewed six</p>	<p>(i) Ensure behavioural assessments are completed for residents with</p>

<p>process and are documented to serve as the basis for service delivery planning.</p>		<p>behaviour assessment for the dementia resident. Three of the four files had risk assessments reviewed six monthly. The service has commenced using the InterRAI tool. However, the manager reports that difficulty in accessing InterRAI training for staff means that the service has been unable to meet all InterRAI contractual obligations (link 1.2.7.5). This aspect of the finding is deemed negligible risk.</p>	<p>monthly (this was now current).</p>	<p>behaviours that challenge.</p> <p>(ii) Ensure that risk assessments are reviewed at least six monthly.</p> <p>60 days</p>
<p>Criterion 1.3.6.1 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>Staff interviewed described appropriate care being provided (including where documentation was absent) and residents and family members interviewed stated the care provided was of a high standard. The GP interviewed also commented on the high standard of care provided. However, care plans do not always guide staff around required care interventions and monitoring charts are not always completed. Wound care assessment and reviews were incomplete. Wound management plans are documented for all wounds where there is an individual set of wound documentation for each wound (some wounds have more than one wound on the same plan).</p>	<p>(i) Two residents have more than one wound on one set of documentation. One rest home resident has four ulcers on one wound file and the assessment and plan are combined for these four ulcers (one other ulcer for this resident is on separate paper work). The rest home tracer (link 1.3.3) has multiple skin breakdown areas and two pressure injuries (one grade 2 and one grade 1), spread over two sets of documentation, with some wounds interchanging between the two sets of documentation. It was not possible to ascertain from documentation exactly how many wounds this resident has and the relieving nurse was unsure, as the wounds did not require changing on audit day.</p> <p>(ii) Excluding the wounds above, a further three of eighteen wounds did not have a comprehensive wound assessment documented.</p> <p>(iii) Excluding the wounds in point (i), review times for each wound could not be established. Nine of the further, eighteen wounds had not been reviewed in the</p>	<p>(i), (ii) and (iii) Ensure all wounds have an individual assessment plan and review, with reviews completed in stated timeframes.</p> <p>(iv) Ensure that all required interventions are documented in care plans including short-term care plans for short-term needs.</p> <p>(v) Ensure that two hourly turns and behaviour monitoring are completed and documented where these are indicated.</p> <p>30 days</p>

			<p>required timeframe.</p> <p>(iv) Two of five residents care plans did not document interventions for all required needs. The rest home tracer did not have catheter management, hoist use, constipation or the need for feeding identified in the care plan. The dementia tracer did not have the management of challenging behaviour, the use of a walker and a sensor mat and the management of falls documented in the care plan. This resident also did not have a short-term care plan developed following a recent finger fracture.</p> <p>(v) The rest home tracer did not have two hourly turns documented as occurring (staff reported they were) and the dementia tracer did not have behaviour monitoring documented.</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.