# Lakewood Rest Home Limited - Lakewood Rest Home

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Lakewood Rest Home Limited

**Premises audited:** Lakewood Rest Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 23 April 2018 End date: 24 April 2018

**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:** 35

# 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** |
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|  | 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 |
|  | 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

Lakewood rest home is certified to provide dementia level care for up to 36 residents. On the day of audit there were 35 residents. The service is privately owned and managed by a registered nurse manager. He is supported by three registered nurses, an administrator and care staff.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, management and staff.

The service continues to implement a quality system, policies and procedures and education plan to enable staff to deliver best care. Family/whānau interviewed commented positively on the standard of care and services provided at Lakewood rest home.

This audit has identified improvements are required around incomplete documentation and aspects of medication prescribing.

## Consumer rights

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| 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. |

Policies are implemented to support residents’ rights, communication and complaints management. Family are involved in the initial care planning, provided with ongoing feedback and informed if an incident/accident or a change in resident’s health status occurs. Care plans accommodate the choices of residents and/or their family/whānau.

## Organisational management

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| 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. |  | Standards applicable to this service fully attained. |

Lakewood rest home is implementing a quality and risk management system that supports the provision of clinical care. Quality and risk data is collated for residents’ falls, infection rates, complaints received, restraint use, pressure injuries and medication errors. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. A roster provides sufficient shifts to cover for the delivery of care and support to rest home residents.

## Continuum of service delivery

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| 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. |

The registered nurses are responsible for each stage of service provision. A registered nurse completes initial assessments, risk assessments, interRAI assessments and long-term care plans within the required timeframes. Care plans are evaluated at least six monthly and meet the residents’ current needs and supports.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three monthly.

A diversional therapist oversees the activity team and coordinates the activity programme. A 24-hour multidisciplinary care plan identifies a resident’s behaviours and activities or diversions that are successful.  The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident.  Individual activity plans are developed in consultation with resident/family.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Nutritional snacks are available over a 24-hour period.  There is dietitian review and audit of the menus.  Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. All staff are trained in food safety.

## Safe and appropriate environment

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

The building has a current building warrant of fitness.

## Restraint minimisation and safe practice

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| 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 is a restraint policy that includes the provision of a non-restraint environment. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register. There are currently four residents assessed as requiring restraint and one resident using enablers. Appropriate assessments, care planning, monitoring and evaluations are in place around restraint and enabler use.

## Infection prevention and control

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| 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. |

The infection control coordinator (registered nurse) is responsible for coordinating education and training for staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

## Summary of attainment

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

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| **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 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 1 | 1 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The manager is responsible for ensuring complaints are addressed within the required timeframe and maintains contact with the complainant throughout the complaints process. Complaints procedure information is provided to relatives during the admission process. Two complaints received in 2017 were reviewed and reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. There have been no complaints received for 2018 to date. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner. Discussions with families confirmed they were provided with information on complaints during their entry to the service. Relatives can lodge formal or informal complaints through verbal and written communication, resident/relatives’ meetings, and complaint forms. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. All six relatives interviewed state they were welcomed on entry and were given time and explanation about the services and procedures. Evidence of communication with family/whānau is recorded on the accident/incident form and in the residents’ progress notes. Accident/incident forms reviewed identified family had been kept informed. Relatives interviewed stated that they were informed when their family member’s health status changed. A quarterly newsletter is provided for relatives. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lakewood rest home is owned and managed by a registered nurse. The home provides dementia level care for up to 36 residents. On the day of audit there were 35 residents in total (34 residents under the age-related contract and one respite resident). The manager has owned Lakewood for the past 14 years. The manager has qualifications in education and mental health. One full time registered nurse has been in the role just over one year and another for three years.  The service has a business plan, and a quality programme. An annual quality plan is in place and the business/quality programme has been reviewed for 2018.  The manager has completed at least eight hours of professional development relating to managing a rest home. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management programme is in place. Interviews with the manager and staff reflect their understanding of the quality and risk management systems that have been put into place. An annual quality plan for 2018 has been developed.  There are procedures to guide staff in managing clinical and non-clinical emergencies. 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. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents’ falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in quality meetings, and full staff meetings. Resident meetings are held with follow-up of issues and discussions are completed.  A relative survey was last conducted in April 2018, with all respondents advising that they are happy with all aspects of the service.  The service collects information on resident incidents and accidents as well as staff incidents/accidents. The service has a health and safety management system and a hazard register is in place. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. The owner manager states he is more aware of his responsibilities since the new legislation.  Falls prevention strategies are implemented and could be described by staff. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.  The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow-up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, staff meetings and RN meetings reflect a discussion of incident statistics and analysis.  Twelve paper based resident related incident reports for February and March 2018 were reviewed. All reports and corresponding resident files reviewed evidence that families were notified following an incident. Unwitnessed falls did not always include appropriate neurology observations as per policy (link to 1.3.6.1). |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (registered nurse, two caregivers, one cook and one diversional therapist) included evidence of the recruitment process, signed employment contracts, police vetting and completed orientation programmes and annual performance appraisals. Staff turnover was reported as low.  The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. The owner manager actively promotes a Careerforce training programme for all staff and has a Careerforce assessor on staff. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. There are currently 13 of the 17 caregivers that have completed core dementia NZQA standards. Three of the four caregivers, who have not completed the required unit standards, have commenced employment in the past six months. One other caregiver, employed for over six months has completed two modules and progress is being actively monitored by the manager.  A completed in-service calendar for 2017 exceeded eight hours annually. There is a structured education programme for all staff. Competencies (hand hygiene, chemical, fire, hoist, H&S, IC and medication) are completed annually for staff and the register identifies these are up-to-date. The owner manager and registered nurses attend external training including conferences, seminars and education sessions with the local DHB. Two of the current three RNs are interRAI trained with the third scheduled to begin training in May this year. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Lakewood rest home has a weekly roster in place, which provides sufficient staffing cover for the provision of care and service to residents. The manager (registered nurse) is on-site Monday to Friday. There is a registered nurse on morning shift, seven days a week and a RN on afternoon shift for four days a week. There are three full shifts and one short shift caregiver on all morning duties. On afternoon there is a minimum of one long shift and two short shifts with additional support from either the RN or a senior caregiver. There are two senior caregivers on night shifts. The owner manager (RN) or a registered nurse cover 24/7 on call. There is at least one staff member on each duty with a first aid certificate. Staff and relatives interviewed confirmed that there are sufficient staff rostered on for the provision of care for residents. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Ten medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. The electronic medication charts reviewed identified that the GP had reviewed all resident’s medication three monthly and all allergies were noted. All resident charts included photo identification. Not all medication charts included indications for use for ‘as required’ medication.  All senior staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications including signing for medications at the time of administration. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses robotic medications. All medications are checked by an RN on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. All medications were in date and stored appropriately.  The service does not use standing orders. Lakewood is a secure dementia unit and there are no self-medicating residents.  The medication fridge temperature is recorded daily and is maintained within an acceptable range. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All food is prepared and cooked on-site at Lakewood rest home. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. There are two, five weekly seasonal menus that have been reviewed by a dietitian. The meals are prepared in a small functional kitchen and served directly to the residents in the dining room, which is located adjacent to the kitchen. The cook receives notification of any resident dietary changes and requirements. Dislikes and food allergies are known and accommodated. Resident weights are monitored monthly. Residents displaying weight loss are reviewed and monitored by the general practitioner and the dietitian as needed. Supplements are provided to residents with identified weight loss. Drinks and snacks are available over 24/7 for residents.  The daily menu is posted in the dining room. Feedback on the service is through observation of residents at mealtimes. Family meetings and surveys provide an opportunity for relative feedback on the food service. Families interviewed stated they were satisfied with food service.  The service has food control plan registered with the local council. Fridge and freezer temperatures are checked and recorded daily. Food temperatures are documented daily. Foods were date labelled and stored correctly. A cleaning schedule is maintained. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Registered nurses and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the registered nurse will initiate a referral (e.g., wound specialist nurse). If external medical advice is required, this will be actioned by the GP. Interviews with registered nurses and healthcare assistant demonstrated an understanding of the individualised needs of residents. Care plan interventions included interventions to meet residents’ assessed needs. There was evidence of monitoring charts in use (but not limited to), including security checks, food and fluid charts, blood glucose level monitoring, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. Not all monitoring following an adverse event was documented as required by the organisations policy.  Adequate dressing and medical supplies were sighted in the treatment room on the day of audit and staff interviewed reported they had access to sufficient dressings. Sufficient continence products are available and resident files include a continence assessment. Specialist continence advice is available as needed and this could be described.  On the day of audit, there were ten wounds including three supra pubic catheter insertion sites, four skin tears, one chronic wound and two stage two pressure injuries (one was resolved to a stage one and the other was healed on day two of the audit). Not all wound documentation was fully completed. All wounds have been reviewed in appropriate timeframes.  Care staff interviewed were able to describe management of individual residents and their care. Care staff were observed to be very supportive to residents on the day of audit. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs a qualified diversional therapist, five days a week, from nine to five and a second activities trainee who works from midday to 8.00 pm Monday to Friday and alternate Saturdays from 9.00 am to 5.00 pm. A caregiver is also rostered as an activities assistant on alternate Saturdays and every Sunday. An activities programme is provided for seven days a week.  An individual activities and social profile and 24-hour plan has been developed for each individual resident based on assessed needs. Progress notes are maintained on a weekly basis. The resident’s activities plan is evaluated monthly and six monthly and documents progress towards meeting individual goals. Resident files reviewed identified that the individual activity plan is reviewed at the same time as the care plan review occurs.  The programme is planned monthly and additional activities are supported by the caregivers. Activities planned for the day are displayed on noticeboards around the facility. The programme reflects the resident’s interests and abilities and they have choice in their level of participation. Activities include (but are not limited to) newspaper reading, exercises, entertainment, bowls and other indoor games, walks, quizzes, and reminiscing, painting, arts and crafts, and board games. One-to-one support is provided in situations where residents are unable to participate in group activities. Outings occur regularly. Attendance records are maintained.  A newsletter is sent to resident families every three to four months along with an invitation to attend relatives’ meetings. Activities are regularly evaluated with residents and family to ensure that the activity programme is appropriate for the residents who currently reside at Lakewood. The activities coordinators stated at interview that residents are asked frequently to give verbal feedback and asked for suggestions.  Six family interviewed spoke positively of the programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six monthly or earlier if there is a change in health status. There was at least a three-monthly review by the GP. Reassessments have been completed using interRAI LTCF and other relevant assessment tools for residents who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness which expires on 1 June 2018. Hot water temperatures are recorded and are consistently recorded between 43 and 45 degrees Celsius. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Lakewood rest home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the designated infection control coordinator with support from the infection control team. The infection control team (owner manager and two registered nurses) meet regularly. Monthly infection data is collected for all infections based on signs and symptoms of infection and is analysed. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary in the electronic database. This data is monitored and evaluated monthly and compared month-by-month. Infection control is discussed at all staff meetings. Minutes are available for staff. Spot infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.  If there is an emergent issue, it is acted upon in a timely manner. There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were four residents with restraint authorities for either lap belts or chair tables and monitoring plans in place, however none of these are in current use. There is one resident using a chair table as an enabler. Enabler use is voluntary. Staff interviews, and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP) and challenging behaviour management and de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. |

# 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)** |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The GP is responsible for the prescribing of all medications and reviews the resident’s medication at least 3 monthly. Not all ‘as required’ medication has indications for use documented. The GP had documented as per discharge recommendations on one residents chart. | Three of twelve medication charts did not have ‘indications for use’ for ‘as required’ medications. | Ensure all as required medication includes indications for use.  60 days |
| 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. | PA Low | The care staff complete an assessment of the resident following any adverse event, and notify the registered nurse. In the accident and incident forms reviewed, neurological observations had not been completed following all falls, as required by the organisational policy. Five of ten wounds had all wound care documentation completed and dressings completed at the documented frequency. | i) Three of eight accident and incident forms reviewed for residents following an unwitnessed fall, did not have neurological observations recorded as required by the organisational policy  ii) Three of ten wound care plans sampled did not follow the frequency as documented in the wound management plans.  iii) Three of ten wounds did not have evaluations documented with each review of the wound. | i) Ensure that neurological observations are completed according to the organisational policy for all residents following an unwitnessed fall.  ii) Ensure that dressings occur at the frequency documented in the wound management plan.  iii) Ensure that all wound care documentation is fully completed.  90 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.