

# Cunliffe House Retirement Home 2006 Limited - Cunliffe House Rest Home

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## 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:** Cunliffe House Retirement Home 2006 Limited

**Premises audited:** Cunliffe House Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 30 May 2019 End date: 31 May 2019

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit: 15**



# Executive summary of the audit

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## 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

Cunliffe House rest home has been owner/operated for 13 years. The service provides rest home level care for up to 23 residents. On the day of the audit there were 15 residents. The owner/operators are supported by a part-time registered nurse and stable workforce. Residents and family interviewed were complimentary of the service they receive.

This surveillance audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, a family member, staff and management.

The service has addressed one of two findings from the previous audit around medications. Further improvements are required in relation to aspects of implementation of care.

This audit also identified that improvements are required around, adverse event management, timeliness of interRAI and care planning, monitoring of care reports and care plan evaluations.

## 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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Communication with residents and family was evidenced in care plans and confirmed on interviews. Complaints processes are implemented, and complaints, and concerns are actively managed. There have been no complaints since the previous audit. Residents and family interviewed praised the care provided at the service.

## 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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There is a business plan with goals for the service that has been regularly reviewed. The quality system has been implemented. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe 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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The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. The care plans reviewed were consistent with meeting residents' needs. Initial care plans are documented on admission. Risk assessments are completed and reviewed. Where progress was different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan. Long-term care plans are evaluated. Activities were provided either within group settings or on a one-on-one basis. Medication policies reflect current guidelines. Nutritional needs of residents are provided in line with resident needs, and residents commented positively on the food service provided.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a current building warrant of fitness. Fire evacuations have been undertaken six monthly. Electrical testing has been completed as required. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade.

## 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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Cunliffe House has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. Cunliffe House rest home has maintained a restraint-free environment.

## 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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The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. 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)
<b>Standards</b>	0	12	0	2	2	0	0
<b>Criteria</b>	0	36	0	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	FA	<p>The complaints procedure is provided to residents and relatives at entry to the service. A paper-based record of all complaints, both verbal and written, is maintained by the owner manager using a complaints' register. The owner/manager and the RN operate an 'open door' policy. There have been no complaints since the previous audit. Two caregivers interviewed were able to describe the process around reporting complaints. Interview with the two owner/managers confirmed all complaints are managed in line with Right 10 of the Code. Five residents interviewed, and family members, advised that they are aware of the complaint's procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Policies and procedures are in place to guide staff on the process around open disclosure. The two owner managers and registered nurse confirmed family are kept informed. Three relatives interviewed, stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management and the registered nurse. The most recent family/resident survey achieved positive feedback for communication. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status. Families are encouraged to visit.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident</p>

communication.		should they wish to do so. There is access to an interpreter service as required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Cunliffe House provides rest home level care for up to 23 residents, with 15 occupied beds on the day of the audit. All residents are under the Age Related Residential Care Services Agreement. There is a documented service philosophy, mission and vision and a strategic plan from August 2018. Cunliffe House rest home is managed by co-owners with many years' experience in aged care. Clinical oversight is provided by a registered nurse also available 24/7 on call. Registered nurse cover is provided on site Monday to Thursday. The two on site co-owners/managers have maintained at least eight hours annually of professional development activities related to managing a rest home. This includes attendance at the aged care conference, a residential full day workshop and the managers and provider (DHB) forums quarterly in 2018 and 2019. They also own another rest home facility. There are four directors in total including the two on site owner/managers and two others.</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>	FA	<p>A strategic business plan and quality and risk management programme is in place. Strategic goals for 2019 are documented and monitored monthly and annually. Quality is monitored through internal audits, adverse event collation and analysis, infection rates, resident satisfaction, and staff retention. Internal audits monitor compliance with policies, and corrective actions are implemented where required. A three-monthly management meeting involving the owners and RN evidence detailed discussion on quality indicators.</p> <p>Policies and procedures are provided by an external consultant and a system is in place for regular review. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes. Staff have input into the staff meetings, where there is discussion around complaints, compliments, health and safety, adverse events, infection prevention and control, audit and survey results, corrective actions and improvements. Staff interviewed (two caregivers, one cook, one activities coordinator and one cleaner) state they are well informed and receive quality and risk management information such as accident/incident trends and infection control statistics. There are annual resident satisfaction and family satisfaction surveys and food satisfaction surveys completed. Suggestions for improvements are identified and implemented with evidence of sign off. Survey results from October 2018 reflected satisfaction on all aspects of the service.</p> <p>The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified. A health and safety programme is in place, which includes managing identified hazards. Health and safety discussion occurs at monthly staff meetings.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>Discussions with the two managers confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. This has not been required.</p> <p>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 facilities quality programme and this is used for trending and comparative purposes. Minutes of the monthly staff meetings and three-monthly management meetings reflect a discussion of incident statistics and analysis.</p> <p>Ten resident related incident reports for March and April 2019 were reviewed. Not all incidents reflected a clinical assessment and follow-up by a RN. The forms evidenced families are informed where appropriate.</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>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one registered nurse (RN), two caregivers, one activities coordinator, one housekeeper and one cook) included a comprehensive recruitment process which includes: reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals. The RN file included a current annual practising certificate. The registered nurse is supported to maintain professional competency.</p> <p>The orientation programme includes documented competencies and induction checklists. There is an implemented annual education and training plan that exceeds eight hours annually. Care staff are supported to gain aged care qualifications with 80% of staff having achieved level three or four Careerforce or equivalent. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. The RN has completed interRAI training. All senior care staff have current first aid certificates.</p> <p>Family and residents stated that staff are knowledgeable in their role. Annual competencies are completed for all staff involved in medication administration.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate,</p>	<p>FA</p>	<p>There is policy in place to determine staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>There are two co-owner/managers and a trainee manager who provide on-site support. The registered nurse works four days a week for 24 hours a week with on call 24/7. A second RN who previously worked at Cunliffe provides weekend on call support on alternate weekends. Two caregivers are on site in the morning and</p>

<p>and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>afternoon (one short and one long shift on each) with one caregiver overnight. Caregivers complete laundry, weekend cleaning and food services in the evening. There is one cleaner employed Monday to Friday. Caregivers interviewed stated that they can access on call staff when needed.</p> <p>Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RN, and the owner/managers (non-clinical) who respond quickly to after-hours calls.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Cunliffe House utilises a paper-based medication management system. There are medication policies and procedures that follow recognised standards and guidelines for safe medicine management.</p> <p>All residents have individual medication orders with photo identification and allergy status documented. Regular medications were signed for individually and evidences an improvement from the previous audit. Prescribing of medications met legislative requirements. The service uses a four-weekly blister pack system for tablets, and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Three self-medicating residents (for inhalers) had a self-medication competency completed and authorised by the GP.</p> <p>Short-life medications (i.e., eye drops, nasal drops and ointments) are dated once opened and no evidence of decanted medication. This is an improvement from the previous audit. Education on medication management has occurred with competencies conducted for the registered nurse and senior caregivers with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three-monthly. A senior caregiver was observed administering medications and followed correct procedures.</p> <p>There were no expired medications stored. There were no controlled drugs in use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Cunliffe House employs a qualified cook and all meals and baking are cooked on site. There is a food services manual in place to guide staff. There is a four-weekly seasonal menu which had been reviewed by a dietitian. The service has an approved food control plan in place dated 11/6/19. A resident nutritional profile is developed for each resident on admission and reviewed six monthly by the RN. A copy of the resident's dietary needs is provided to the kitchen staff. The kitchen is able to meet the needs of residents who require special diets and the cooks work closely with the registered nurse. The kitchen staff have completed food safety training. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.</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>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit however not all reviews are documented (Link 1.3.3.4.) There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.</p> <p>Dressing supplies are available and treatment rooms are adequately stocked for use. Wound assessments, management plans and evaluations for two current and two healed wounds were reviewed, however not all details were fully documented. The RN interviewed stated they have access to an external wound care specialist as required.</p> <p>Continence products are available and resident files include a 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 by the RN interviewed.</p> <p>Monitoring forms in place include (but are not limited to): monthly weight, blood pressure and pulse, food and fluid charts, blood glucose monitoring and behaviour however not all required monitoring is evidenced. This is a continued short fall from the previous audit.</p> <p>Short-term care plans are used for changes in health (link 1.3.8.2).</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 activities coordinator provides an activities programme for four hours a day over five days each week Monday-Friday. The experienced activities coordinator is a qualified caregiver who is working towards completing her diversional therapy qualification. The programme is planned monthly and residents each receive a personal copy. Residents are reminded of activities for the day. The monthly programme is flexible to meet residents' preferences and outings. Activities are meaningful and include (but are not limited to); newspaper reading and discussions, crafts, quizzes, walks, movies and housie. Raised vegetable gardens have been built for one resident who enjoys gardening. One-on-one time is spent with residents who choose not to join in group activities. All festivities and birthdays are celebrated. The community is accessed with visits from church representatives, fortnightly club visits shopping trips each week and weekly outings to community places of interest.</p> <p>A resident profile is completed on admission. Each resident has an individual activity plan which is reviewed six monthly at the same time as the long-term care plan. The service receives feedback on activities through one-on-one feedback, resident's meetings and surveys. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8:</p>	<p>PA Low</p>	<p>All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care</p>

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>plan developed. Care plans had been evaluated for five long-term residents, however, did not always occur at least six monthly (link 1.3.3.3). Written evaluation did not always identify if the desired goals had been met or unmet. The. Ongoing RN evaluations and review following adverse events are not always documented within the progress notes (link 1.3.3.4).</p> <p>The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. Short-term care plans were evident for the care and treatment of residents, however, not all short term care plans evidenced review.</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 building has a current building warrant of fitness that expires 1 July 2019. A gardener maintenance employee is on site one day a week to attend to reactive maintenance issues. An owner/director is on site two or three days a week for maintenance and repairs and available at other times for facility matters. There is a record of maintenance and repairs. A planned maintenance plan is in place and completed for 2019 to date. The plan includes checks on all equipment, call bells and monthly hot water temperatures. Essential contractors are available 24 hours. Electrical testing is completed annually. Annual calibration, functional checks and electrical testing and tagging of equipment was completed by external contractors last August 2018.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the well maintained and landscaped outdoor areas. Seating and shade is provided. There is a designated smoking area for residents who smoke.</p> <p>The caregivers interviewed stated they have sufficient equipment including mobility aids and wheelchairs (if required) to safely deliver the cares as outlined in the residents' care plans.</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>Infection surveillance and monitoring is an integral part of the infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection and monitoring also occurs on antibiotic prescribing. Surveillance of all infections was entered onto a monthly facility infection summary and staff informed. The registered nurse uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service. There have been no outbreaks since previous audit.</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>Restraint minimisation and safe practice policy and procedure includes definitions of an enabler and restraint. Cunliffe House Rest Home has an assessment and care planning process that includes interventions for calming and de-escalation, to minimise the need for any restraint interventions. There are currently no residents at Cunliffe House Rest Home requiring restraint or using an enabler. Restraint is an agenda item at monthly staff meetings. Restraint training last occurred June 2018.</p>
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## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	All incidents are recorded on a paper-based system at the time of the incident. The forms evidence if the RN and family has been informed. The forms are placed in a tray for RN review and follow-up, however, there is not always documentation to evidence this has occurred.	Four of ten incidents reviewed did not evidence the RN had assessed the resident or considered opportunities to minimise future events.	<p>Ensure residents are reviewed following adverse events and that opportunities to minimise future events is considered.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	The RN is responsible for resident assessments, care planning and evaluations. Recent changes in RN support with the unexpected resignation of a senior RN have contributed to delays in completing requirements.	<p>(i) Three of five interRAI assessments did not evidence reviews had been completed within six monthly timeframes.</p> <p>(ii) Three of five long-term care plans have not been completed within</p>	(i)-(ii) Ensure interRAI assessments and long-term care plans are completed at least six monthly or as required in response to change in health requirements.

			six monthly timeframes.	90 days
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>The RN is responsible for reviewing residents following changes in health, adverse events and in conjunction with GP visits and documenting in the resident progress notes. The RN interviewed stated all residents are reviewed regularly, however this is not always documented in progress notes.</p>	<p>Four of five resident files did not evidence regular review by the registered nurse including follow-up following adverse events.</p>	<p>Ensure all residents are reviewed by a RN in response to adverse events and regularly.</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>	<p>PA Moderate</p>	<p>The residents' files include a urinary continence assessment, bowel management plan, and continence products used. Monitoring occurs for blood pressure, weight, blood glucose, pain and behaviours. Not all monitoring had been implemented. Wound assessment and management plans were in place but were not fully completed.</p>	<p>(i) There was no hourly monitoring in place for a resident at high risk of falls as per the care plan.</p> <p>(ii) A wound management plan in place evidenced two wounds on the same plan. Individual wound assessments and management plans for each wound were not evident.</p> <p>(iii) The wound management plan did not evidence review at planned intervals.</p>	<p>(i) Ensure interventions are implemented as per the documented care plan.</p> <p>(ii) Ensure each wound is assessed and management plans documented individually.</p> <p>(iii) Ensure wound management plans evidence review at planned intervals.</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or</p>	<p>PA Low</p>	<p>Short term care plans are documented for acute changes in health, however, there is not always evidence of review. Long term care plans are reviewed, and evidence dates, however, evaluations do not always include progress towards</p>	<p>i) Four of five long-term care plans evaluations reviewed did not consistently evidence progress towards goals.</p>	<p>i) Ensure care plan evaluations include progress towards goals.</p> <p>ii) Ensure short-term</p>

<p>intervention, and progress towards meeting the desired outcome.</p>		<p>goals.</p>	<p>ii) Three of six short-term care plans reviewed did not evidence evaluation and either resolution or changes made to the long-term care plan.</p>	<p>care plans evidence regular review and are either resolved or added to the long-term care plan.</p> <p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.